

<i>SERFF Tracking Number:</i>	<i>DDPA-126229677</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Dentegra Insurance Company</i>	<i>State Tracking Number:</i>	<i>42939</i>
<i>Company Tracking Number:</i>	<i>SLE-GRP-09-004</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>SLE-GRP-AR</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Dentegra Insurance Company

Product Name: SLE-GRP-AR

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: DDPA-126229677 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 42939

Co Tr Num: SLE-GRP-09-004

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Kellee Wamble

Disposition Date: 07/24/2009

Date Submitted: 07/20/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Due to the specific changes to the contract, group application and EOC forms to meet the requirements of our domiciliary state of Delaware. However, forms SLE -DENTEGRA-GRP-AP-DE; G-SLE-C-DE-09; G-SLE-E-DE-09; SLE-E-AMEND; SLE-C-AMEND and SLE-AX-G-AP were submitted to Delaware for approval on July 2, 2009. We will notify you when we receive approval.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 07/24/2009

Explanation for Other Group Market Type:

State Status Changed: 07/24/2009

Deemer Date:

Corresponding Filing Tracking Number:

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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: SLE-GRP-AR  
Project Name/Number: /

**Filing Description:**

Enclosed for your approval are the following group dental forms:

G-SLE-C-AR -09, Group Dental Contract;  
G-SLE-E-AR-09, Group Dental Evidence of Coverage (EOC/Certificate);  
DENTEGRA-GRP-AP Group Application;  
C-AMEND, Group Contract Amendment;  
AX-G-AP, Appendix to Group Application; and  
E-AMEND, Group EOC Amendment.

These are new forms and do not replace any on file with your Department.

This is a dental PPO product that will be marketed and sold by licensed agents in your state. forms will be used for our employer/employee groups, labor unions or association groups located in Arkansas. This is a dental indemnity product that will be marketed and sold by licensed agents in your state. They will not be used as an individual policy. The forms are substantially similar to our Dentegra PPO product filing G-PPO-C-AR-09 et al. submitted under SERFF Filing # DDPA-126219810 on July 10, 2009. These forms will be used when the group purchases the dental PPO product and desires to use Delta Dental PPO and Delta Dental Premier Networks, rather than the Dentegra network. The contracts will be underwritten by Dentegra Insurance Company and administered by Delta Dental Insurance Company. To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Benefits, coinsurance percentages, deductibles, waiting periods and eligibility requirements will be determined by the needs of the Contractholder. However, the Insured/Enrollee is free to choose any dentist he or she wishes. We give you our assurance that if any differentials in coinsurance percentages, with this product in your jurisdiction they will not vary anymore than twenty-five percent (25%).

Our effective date for use of these forms will be the earlier of the date the filing is approved or the date it is deemed approved by your Department.

Text in [brackets] in the forms are variable. All numerical data is also considered variable unless required by state law. Also enclosed for your information are Variable Exhibits of the Contract and EOC with comments. The comments explain what is variable in each respective document and the various options that could be used. All benefit information (procedures, exclusions, limitations and coinsurance amounts) is considered variable since a larger Contractholder may

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request certain procedures/amounts be omitted/changed/added in order for their new plan to match their current plan.

Also enclosed for your information is a copy of the enrollment form, DIC-Form 3464 ST that will be used to request coverage under a group contract issued on these forms.

## Company and Contact

### Filing Contact Information

Kellee Wamble (Dentegra), Regulatory Analyst kwamble@dentegra.com  
 1130 Sanctuary Parkway, Suite 600 (770) 641-5217 [Phone]  
 Alpharetta, GA 30009 (770) 641-5193[FAX]

### Filing Company Information

Dentegra Insurance Company CoCode: 73474 State of Domicile: Delaware  
 100 First Street Group Code: 2479 Company Type: LAH  
 San Francisco, CA 94105 Group Name: Dentegra Group, Inc. State ID Number:  
 (866) 714-7730 ext. [Phone] FEIN Number: 75-1233841  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? Yes  
 Fee Explanation: The domicillary state of Delaware charges \$50.00 per form and the filing is requiring that 6 forms be submitted.

6 forms x \$50.00 = \$300.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Dentegra Insurance Company	\$300.00	07/20/2009	29303591

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TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	SLE-GRP-AR		
Project Name/Number:	/		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/24/2009	07/24/2009

*SERFF Tracking Number:*      *DDPA-126229677*

*State:*      *Arkansas*

*Filing Company:*      *Dentegra Insurance Company*

*State Tracking Number:*      *42939*

*Company Tracking Number:*      *SLE-GRP-09-004*

*TOI:*      *H10G Group Health - Dental*

*Sub-TOI:*      *H10G.000 Health - Dental*

*Product Name:*      *SLE-GRP-AR*

*Project Name/Number:*      */*

## **Disposition**

Disposition Date: 07/24/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	DDPA-126229677	State:	Arkansas
Filing Company:	Dentegra Insurance Company	State Tracking Number:	42939
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TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	SLE-GRP-AR		
Project Name/Number:	/		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Enrollment Form	Approved-Closed	Yes
Supporting Document	Variable Information Forms	Approved-Closed	Yes
Form	Group Contract	Approved-Closed	Yes
Form	Group EOC/Certificate	Approved-Closed	Yes
Form	Group Contract Amendment	Approved-Closed	Yes
Form	Group EOC/Certificate Amendment	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Appendix to Group Application	Approved-Closed	Yes

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Product Name: SLE-GRP-AR  
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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G-SLE-C-AR-09	Policy/Cont	Group Contract ract/Fratern al Certificate	Initial		52	G-SLE-C-AR-09clean.pdf
Approved-Closed	G-SLE-E-AR-09	Certificate	Group EOC/Certificate	Initial		52	G-SLE-E-AR-09clean.pdf
Approved-Closed	SLE-C-AMEND	Policy/Cont	Group Contract ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		61	SLE-C-AMEND.pdf
Approved-Closed	SLE-E-AMEND	Certificate	Group Amendmen t, Insert Page, Endorseme nt or Rider	Initial		61	SLE-E-AMEND.pdf
Approved-Closed	SLE-DENTEGRA-GRP-AP	Application/	Group Application Enrollment Form	Initial			SLE-DENTEGRA-GRP-AR-AP.pdf
Approved-Closed	SLE-AX-G-AP	Policy/Cont	Appendix to Group ract/Fratern al Certificate: Amendmen t, Insert Page,	Initial		61	SLE-AX-G-AP.pdf

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<i>Project Name/Number:</i>	<i>/</i>		
	<b>Endorseme</b>		
	<b>nt or Rider</b>		





**DENTEGRA INSURANCE COMPANY**

1130 Sanctuary Parkway  
Suite 600  
Alpharetta, Georgia 30009  
(877) 280-4204

**Group Dental PPO Insurance Contract**

[Group's Name], ("Contractholder") has applied for a group dental insurance Contract with Dentegra Insurance Company (Dentegra). The following terms will apply:

- I. Contractholder will pay Dentegra the monthly Premium stated in this Contract.
- II. Dentegra has accepted the Application submitted by the Contractholder. A copy is attached and made a part of this Contract. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Appendix A. The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.
- III. [Contractholder will give each Primary Enrollee a certificate furnished by Dentegra.] [Contractholder will give each Primary Enrollee electronic access to a certificate of coverage furnished by Delta Dental.] Contractholder will also distribute to its Enrollees any notice from Dentegra which affects their rights under this Contract.

So long as Contractholder pays the Premiums stated in Article 3, Dentegra agrees to provide the Benefits described in Article 4. This Contract will continue from year to year until terminated, as stated in Article 8.

This Contract is issued and delivered in the State of Arkansas and is governed by its laws.



**Anthony S. Barth, Vice Chairman**

**UNDERWRITTEN BY:**

**DENTEGRA INSURANCE COMPANY**

1130 Sanctuary Parkway, Suite 600  
Alpharetta, Georgia 30009  
(877) 280-4204

**ADMINISTERED BY:**

**DELTA DENTAL INSURANCE COMPANY**

1130 Sanctuary Parkway, Suite 600  
Alpharetta, Georgia 30009  
(770) 641-5100

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## ARTICLE 1 DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

- 1.01 **Accepted Fee** -- the amount the attending Provider agrees to accept as payment in full for services rendered.
- 1.02 **Benefits (In-Network or Out-of-Network)** -- the amounts that Delta Dental will pay for dental services under this Contract. In-Network Benefits are those covered by this Contract and performed by a Delta Dental PPO<sup>SM</sup> Provider. Out-of-Network Benefits are those covered by this Contract but performed by a Delta Dental Premier<sup>®</sup> Provider or a Non-Delta Dental Provider.
- 1.03 **Claim Form** -- the standard form used to file a claim or request a Pre-Treatment Estimate for treatment.
- 1.04 **Contract** -- this agreement between Delta Dental and Contractholder, including the Application and the attachments listed in Article 9.
- 1.05 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied.
- 1.06 **Contractholder** -- the employer, union or other organization or group contracting to obtain Benefits.
- 1.07 **Contract Term** -- the period during which this Contract is in effect, as shown in Appendix A.
- 1.08 **Contract Year** -- [the 12 months] starting on the Effective Date and each subsequent [12] month period thereafter. [Deductibles and maximums will be determined using this [12] month period rather than on a Calendar Year basis.]
- 1.09 **Deductible** -- a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.
- 1.10 **Delta Dental** -- means collectively, Dentegra Insurance Company and Delta Dental Insurance Company providing and/or administering dental benefit programs. For the purposes of this Contract, Dentegra Insurance Company is the underwriter and Delta Dental Insurance Company is the administrator.
- 1.11 **Delta Dental Premier Provider (Premier Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under a plan and complies with Delta Dental's administrative guidelines.
- 1.12 **Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee)** -- the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating Enrollees.
- 1.13 **Delta Dental PPO Provider (PPO Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under this PPO dental plan and complies with Delta Dental's administrative guidelines.
- 1.14 **Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee)** -- the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating Enrollees.
- 1.15 **Dependent Enrollee** -- an Eligible Dependent enrolled to receive Benefits.
- 1.16 **Effective Date** -- the date the program starts, as shown in Appendix A.
- 1.17 **Eligible Dependent** -- a dependent of an Eligible Employee [or domestic partner] eligible for Benefits under Article 2.
- 1.18 **Eligible [Employee/Member]** -- any [employee/member] [or retiree] as eligible for Benefits under Article 2.
- 1.19 **Enrollee** -- an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".
- 1.20 **Enrollee's Effective Date of Coverage** -- the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.
- 1.21 **Maximum Contract Allowance** -- the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:
- [by a PPO Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
  - by a Premier Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or

- by a Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.
  - [by a PPO Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
  - by a Premier Provider is the lesser of the Submitted Fee on the claim or the Premier Provider's Contracted Fee; or
  - by Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the Program Allowance].]
  - [by a PPO Provider is the lesser of the Submitted Fee on the claim, the PPO Provider's Contracted Fee or the amount shown on the Table of Allowance; or
  - By a Premier Provider is the lesser of the Submitted Fee on the claim, the Premier Provider's Contracted Fee or the amount shown on the Table of Allowance; or
  - by a Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the amount shown on the Table of Allowances.]
- 1.22 **Non-Delta Dental Provider** -- a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Delta Dental's administrative guidelines and has not agreed to accept the contracted fees.
- 1.23 **Open Enrollment Period** -- the month of the year during which employees may change coverage for the next Contract Year.
- 1.24 **Patient Pays** -- Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.
- 1.25 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Enrollee.
- 1.26 **Premium** -- the amounts payable by the Contractholder as provided in Appendix A.
- 1.27 **Primary Enrollee** -- an Eligible Employee enrolled in the plan to receive Benefits.
- 1.28 **Procedure Code** -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.
- 1.29 **Program Allowance** -- the amount determined by Delta Dental for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.
- 1.30 **Provider** -- a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.
- 1.31 **Qualifying Status Change** -- a change in:
- legal marital status (marriage, divorce, legal separation, annulment or death);
  - number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
  - employment status (change in employment status of Enrollee, spouse or dependent child);
  - dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
  - residence (Enrollee, dependent spouse or child moves);
  - a court order requiring dependent coverage; or
  - any other current or future election changes permitted by IRC Section 125.
- 1.32 **Single Procedure** -- a dental procedure that is assigned a separate CDT® number.
- 1.33 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.
- 1.34 **[Table of Allowances** -- the list of covered dental services showing the Procedure Code and the maximum amount paid by for each covered Single Procedure. The Table of Allowances is attached as Appendix B.]

## ARTICLE 2 ELIGIBILITY AND ENROLLMENT

- 2.01 **Reporting**  
[On or before the Effective Date, Contractholder will furnish to Delta Dental, in writing or in electronic media format agreed by Delta Dental and the Contractholder, a listing of eligible Primary Enrollees and Dependent Enrollees. The listing shall include but not be limited to the:
- Primary Enrollees and Dependent Enrollees: names, Enrollee ID numbers, dates of hire, Effective Date of coverage, dates of birth, addresses and gender
  - Dependent Enrollees dependent status; and
  - Primary Enrollees location, if applicable.

The eligibility list shall include all active employees unless the employee waives coverage or the Eligible Employee enrolls in an alternate dental plan offered by Contractholder. [The eligibility list may also include retired employees and surviving spouses of employees.]

Thereafter, before the 10<sup>th</sup> of each month, Contractholder must furnish to Delta Dental in the format agreed to above, a listing indicating specific additions, changes or terminations made during the prior month.] An Enrollee remains enrolled until the Contractholder notifies Delta Dental of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, Contractholder must promptly notify Delta Dental of such change.

[If the Contractholder will report eligibility through Delta Dental's web site, on or before the Effective Date, Contractholder will furnish Delta Dental with an initial report of eligible Primary Enrollees by transmitting all of the Enrollee information as requested by the eligibility update section of the web site. Once Contractholder transmits the Enrollee information through Delta Dental's web site, the information for each Enrollee shall remain effective from the Effective Date of the information until the earlier of the termination of the Enrollee's coverage or the expiration of a Contract Term. An Enrollee remains enrolled until the Contractholder notifies Delta Dental of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, Contractholder must promptly transmit such change via the web site. Contractholder may only use the electronic mail link and accompanying form Delta Dental provides for changes listed on the form. Such revised information shall remain effective until the earlier of the termination of the Enrollee's coverage or the next renewal update by the Contractholder. For renewal of the Contract Term, Contractholder must review and update as necessary all Enrollee information. Contractholder agrees to install and implement any desktop upgrades and/or configuration changes necessary to continue to update Eligibility information. Contractholder agrees to comply with Delta Dental policies and requirements as posted on the Delta Dental web site when accessing or updating information on the Delta Dental web site. Contractholder is responsible for: (1) maintaining the confidentiality of any passwords or other information required to access the Delta Dental web site information; (2) the accuracy of all information that Contractholder provides to Delta Dental through its web site, and; (3) any Contractholder delays in submitting information to Delta Dental through its web site.]

Contractholder will notify Delta Dental in writing or in electronic media of any requests for Premium adjustments for Enrollees who should have been terminated in the event Delta Dental was not previously notified of the termination(s). Retroactivity will be adjusted to the immediately preceding 3 months plus the current billing month.

Delta Dental will not make any payment for services provided to an Enrollee who is not reported to Delta Dental as an Enrollee under this Contract when the service is provided. Also, Delta Dental may not pay Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Delta Dental shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse Delta Dental for any erroneous claim payments made by Delta Dental as a result of incorrect eligibility reporting by the Contractholder.

2.02 Contractholder will permit Delta Dental to audit Contractholder's records to check whether the lists of Primary and Dependent Enrollees are correct and to confirm compliance with Article 3. Delta Dental will give Contractholder written notice within a reasonable time before the audit date.

2.03 **Eligible Employees**

Eligible Employees are full-time employees as indicated on the attached Application. Eligible Employees will become eligible to receive Benefits on the date stated on the attached Application after completing any eligibility periods required by the Contractholder as stated in the attached Application.

2.04 **Eligible Dependents**

Eligible Dependents of an Eligible Employee are:

- Lawful spouse [or Domestic Partner named in Contractholder's Affidavit of Domestic Partnership].
- An unmarried child from birth [to their/end of month of 19th birthday or 25<sup>th</sup> birthday] if a full-time student in an accredited school. Proof of full-time student status must be given to Delta Dental within 60 days when requested. "Children" include natural children, step-children, adopted children, [children of the domestic partner], foster children and children for which the employee has been appointed legal guardian. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. [However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any [Contract/Calendar] Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the [Contract/Calendar] Year immediately following said child's fourth birthday.]
- An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is mostly dependent on the Eligible Person for support and maintenance. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible.

## 2.05 Enrollment of Eligible Employees and Eligible Dependents

- [If Contractholder pays the entire cost of coverage for all Primary Enrollees [and Dependents Enrollees], all Eligible Employees [and Eligible Dependents] are automatically covered under the plan.]  
[If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. If coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, the Primary Enrollee may not re-enroll except during an Open Enrollment Period.]  
[If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.]
- [If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. If Dependent Enrollees coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, then former Dependents-Enrollees may not be re-enrolled at any time, unless there is a court order requiring dependent coverage.]  
[If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]  
[If the Primary Enrollee is paying all of the cost for Dependent Enrollees' coverage in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. However, the eligibility date for young children, under the age of four (4), may be delayed until the beginning of any [Contract/Calendar] Year including the [Contract / Calendar] Year immediately following said child's fourth birthday. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]
- [If both spouses are Eligible Employees, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[If both spouses are Eligible Employees, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]  
[If both spouses are Eligible Employees, one may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[If both spouses are Eligible Employees, one may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]
- All Eligible Dependents [not covered under another group plan] must be enrolled as Dependent Enrollees if dependent coverage is elected.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under this Contract as a Primary Enrollee or a Dependent Enrollee but not both at the same time.

## 2.06 Late Entrant Provision

[A Late Entrant is an Eligible Employee and/or his/her Eligible Dependents who do not enroll for coverage under this Contract within [31] days of the date first eligible, but later become covered. A Late Entrant may also include a person who requests coverage for him/herself and/or his/her Eligible Dependents which was terminated while he/she remained eligible for coverage under this Contract. Benefits for Late Entrants are reduced as shown on Appendix A.]

- 2.07 [Except for an employee absent from work due to a leave of absence [approved by the Contractholder or] governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), an Enrollee will not be covered for any dental services received while a Primary Enrollee is on strike, lay-off or leave of absence. Contractholder must inform Delta Dental of any change in eligibility as required under section 2.01.

Benefits for such Primary Enrollee and his/her Eligible Dependents will resume as follows:

- If coverage is reactivated in the same [Contract/Calendar] Year, Deductibles and maximums will resume as if the Primary Enrollee were never gone.
- If coverage is reactivated in a different [Contract/Calendar] Year, new Deductibles and maximums will apply.

[Coverage will resume the first day of the month after the Primary Enrollee returns to work, provided the Contractholder submits the request to Delta Dental that coverage be reactivated.]

[Coverage will resume the date the Primary Enrollee returns to work, provided the Contractholder submits the request to Delta Dental that coverage be reactivated.]

If an employee is rehired within the same [Contract/Calendar] Year, Deductibles and maximums will resume as if the Primary Enrollee was never gone.]

- 2.08 [A Primary Enrollee loses coverage on the last day of the month [of employment /he is no longer an Eligible Member of the Contractholder/he stops paying the required Premiums for coverage] or on the day this Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee or dependent status is lost.]  
[A Primary Enrollee loses coverage on the day [of termination of employment/he is no longer an Eligible Member of the Contractholder/he stops paying the required Premiums for coverage] or on the day this Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee or dependent status is lost.]

#### *Termination of Benefits on Loss of Eligibility*

Delta Dental will not pay for Benefits for any services received by a person who is not an Enrollee at the time of treatment except for covered services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

#### 2.09 [Continued Coverage Under USERRA]

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if a Primary Enrollee is covered by this Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date the Primary Enrollee fails to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.]

#### 2.10 [Continuation of Coverage Under COBRA]

When the Eligible Employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Delta Dental agrees to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- Continuation of coverage is required to be offered under COBRA;
- The Enrollee requests the continuation within the time frame allowed;
- The Contractholder notifies Delta Dental that the Enrollee has elected to continue coverage under COBRA;
- Delta Dental receives the required Premium for the continued coverage;
- This Contract stays in force.

Delta Dental does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).]

#### 2.11 [Multiple Plan Options]

This Contract is entered into with the understanding that Eligible Employees of the Contractholder have a choice between dental coverage under this Delta Dental plan and one or more alternate programs. Eligible Employees may exercise that choice as follows:

- All Eligible Employees that enroll will be enrolled as Primary Enrollees under the Delta Dental plan unless they elect an alternate plan.
- Except for new employees, enrollment may be filed with Contractholder only during the Open Enrollment Period.
- New employees may enroll within 31 days of employment which will be effective until the next Open Enrollment Period.]

#### 2.12 [Parallel Enrollment]

Eligible Employees and Eligible Dependents who enroll in the Contractholder's medical plan are required to enroll under this dental plan. Eligibility for coverage under this dental plan begins on the date eligibility under the medical plan begins provided that the Eligible Employee has met the eligibility period requirements shown in Appendix A.]

#### 2.13 [Flexible Dual Choice]

This Contract is entered into with the understanding that Eligible Employees of the Contractholder have a choice between dental coverage under this Delta Dental plan and Delta Dental's prepaid dental plan (DeltaCare<sup>®</sup> USA). The Primary Enrollee and his/her covered dependents may move from this PPO plan to the DeltaCare USA plan or from the DeltaCare USA plan to this PPO plan on a monthly basis. The Primary Enrollee and his/her covered dependents will only be covered under one plan at a time. Dental plan changes will be effective the first day of the following month. The Benefits, Limitations and Exclusions listed in this booklet apply when the Enrollee is covered under the PPO plan.]

### ARTICLE 3 MONTHLY PREMIUMS

#### 3.01 Contractholder will remit the monthly Premium in the amount and manner shown in Appendix A for all Primary Enrollees and Dependent Enrollees.

[Contractholder will remit a full month's Premium for Enrollees whose coverage is effective on the first (1st) through the 15th calendar day of a month. Premiums are not due to Delta Dental for Enrollees who are enrolled on the 16th through the last day of a month.

Contractholder will remit a full month's Premium for Enrollees whose coverage is terminated on the 16th through the last calendar day of a respective month. Premiums are not due to Delta Dental for Enrollees whose enrollment is terminated on the first (1st) through the 15th day of a month.]

#### 3.02 [This Contract will not be in effect until Delta Dental receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 31 days from the due date



will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Delta Dental in accordance with the notice requirements of Section 8.01 Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the current three (3) month U.S. Treasury Bill rate.].

[Contractholder will pay all Premiums, including the first month's Premium, to Delta Dental within [60] days following the first calendar day of the applicable month of coverage. This [60] day period includes a 31 day grace period. This Contract will continue in force during this period. However, if the Premium remains unpaid at the end of this period, Delta Dental may terminate this Contract in accordance with the notice requirements of Section 8.01. Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the current three (3) month U.S. Treasury Bill rate.]

- 3.03 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 8.
- 3.04 Delta Dental will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.
- 3.05 Delta Dental may change the rate of monthly Premium whenever the Contract is amended [as stated in Article 3.06,] or whenever the Contractholder requests a change in Benefits. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Delta Dental agree in writing, [except as provided in Articles 3.06 and 3.07].
- 3.06 Premiums are based on the number of covered employees at the beginning of each Contract Term. If the Contractholder reports a [15] percent addition or reduction in the number of covered Primary Enrollees for three (3) months in a row, Delta Dental may propose a choice of changes in Premiums or Benefits to remedy the increase in cost per person which may result from the difference in the number of enrolled employees. Within 31 days, Contractholder will select one of the choices by written notice to Delta Dental. If Contractholder fails to do so, Delta Dental may select one of the choices by written notice to Contractholder. This Contract will be modified for all dental services predetermined and paid after notice.
- 3.07 If during the Contract Term any new or increased tax is imposed on the amounts payable to Delta Dental under this Contract, the amount stated in Appendix A will be increased by the amount of any such new or increased taxes.

#### **ARTICLE 4 BENEFITS, LIMITATIONS AND EXCLUSIONS**

- 4.01 Subject to the limitations and exclusions in this Contract, Delta Dental will pay the Benefits stated for each type of dental service described below when provided by a Provider and when necessary and customary under generally accepted dental practice standards and applicable Benefits. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, for specific services are shown in Appendix A. If an Enrollee receives dental services from a Provider outside the state of Arkansas, the Provider will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

- 4.02 No change in Benefits will become effective during a Contract Term unless Contractholder and Delta Dental agree in writing.
- 4.03 **Enrollee Coinsurance**  
Delta Dental's provision of Benefits is limited to the applicable portion of Provider's fees or allowances specified [in Appendix A/below]. The Enrollee is responsible for paying the balance of any fees or allowances known as the "Enrollee Coinsurance". Contractholder has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such fees or allowances that are discounted, waived or rebated.
- 4.04 **Benefits**  
[Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Appendix A of the Maximum Contract Allowance for the following services:]

- **Diagnostic and Preventive Benefits**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
  - (3) [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]
- **Basic Benefits**
  - (1) [Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).]
  - (2) General Anesthesia or IV Sedation when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
  - (3) [Endodontics: treatment of diseases and injuries of the tooth pulp.]
  - (4) [Periodontics: treatment of gums and bones supporting teeth.]
  - (5) Palliative: emergency treatment to relieve pain.
  - (6) [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]
  - (7) [Restorative: amalgam, synthetic porcelain and plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
  - (8) [Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.]
- **Major Benefits**
  - (1) [Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).]
  - (2) [Endodontics: treatment of diseases and injuries of the tooth pulp.]
  - (3) [Periodontics: treatment of gums and bones supporting teeth.]
  - (4) [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.]
  - (5) [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.]
- **[Orthodontic Benefits]**  
Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.]
- **[Temporomandibular Joint Dysfunction (TMJ) Benefits]**  
Intra-oral services provided by a licensed Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofascial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).]
- **[Implant Benefits]**  
Procedures performed by a Provider for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis.]
- **[Dental Accident Benefits]**  
An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and stayplate.]

**Note on additional Benefits during pregnancy** - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each [12 month period, Calendar Year, Contract Year] while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

#### 4.05 **Limitations on All Benefits - Optional Services**

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth; or
- a precision denture/partial where a standard denture/partial could be used; or
- an inlay/onlay instead of an amalgam restoration; or
- porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown) [; or/.]
- [a composite restoration instead of an amalgam restoration on posterior teeth.]

If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

#### 4.06 **Limitations**

##### • **Limitations on Diagnostic and Preventive Benefits:**

- (1) Delta Dental will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) and topical application of fluoride solutions no more than [twice in any 12 month]. Note that periodontal cleanings are covered as a [Basic Benefit] and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- (2) Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- (3) X-ray limitations:
  - a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
  - d) A complete intraoral series and panoramic film by the same Provider/Provider office are each limited to once every [five (5)] years.
  - e) Bitewing x-rays are limited to [two (2) times in any 12 month period] when provided to Enrollees under 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries.
- (4) [Topical application of fluoride solutions is limited to Enrollees to age 19].
- (5) Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14]. For enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridge or removable partial denture can be placed.
- (6) Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when orthodontic services are a covered Benefit.
- [(7) Sealants are limited as follows:
  - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
  - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application.]

##### • **Limitations on Basic Benefits**

- [(1) Sealants are limited as follows:
  - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
  - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application.]
- (2) Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months] of treatment if the service is provided by the same Provider/Provider Office.
- (3) Delta Dental limits payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a [Major Benefit.]
- (4) [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider/Provider office.]
- (5) [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing. See note on additional Benefits during pregnancy.]

- **Limitations on Major Benefits**

- (1) Crowns and inlays/onlays are covered not more often than once in any five (5) year period except when Delta Dental determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (2) Prosthodontic appliances [and/or implants] that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. [Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental will not pay for bone grafts provided with implants on the same day of service. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.]
- (3) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- (4) Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- (5) [The initial installation of a prosthodontic appliance [and/or implants] is not a Benefit unless the prosthodontic appliance [and/or implant], bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was ] [under a Delta Dental program / or Contractholder's prior plan]
- (6) Delta Dental limits payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement.
  - a) Denture rebase is limited to one (1) per arch in a 24 month period.
  - b) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- [(7) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture.]

- **[Limitations on Orthodontic Benefits**

- (1) The maximum amount payable for each Enrollee during the [Enrollee's lifetime/Calendar/Contract Year] as shown in Appendix A.
- (2) Orthodontic Benefits will be provided in two (2) payments after the person becomes covered, (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months or less, one (1) payment will be made.
- (3) Benefits are not paid to repair or replace any orthodontic appliance received under this program.
- (4) Benefits are not paid for orthodontic retreatment procedures.
- (5) Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Contract Benefit Level and maximum if covered as Benefits under Delta Dental's standard processing policies.
- (6) [Orthodontic Benefits are limited to dependent child Enrollees under the age of 19 or [25 if full-time student]].

- **[Limitations on TMJ Benefits:**

- (1) TMJ Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Contract.
- (2) Delta Dental will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health program which provides TMJ Benefits.
- (3) Benefits are limited to those intra-oral services which would normally be provided by a licensed Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
- (4) Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this program are excluded.
- (5) Any procedure paid under any other category of Benefits by this Contract is not covered as a TMJ Benefit.]

- **[Limitations on Implant Benefits:**

- (1) Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Contract. Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
- (2) Delta Dental will not pay to replace any implant that the Enrollee received in the previous five (5) years.
- (3) Delta Dental will not pay for bone grafts provided with implants on the same day of service.
- (4) Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- (5) Prosthodontic devices and procedures associated with, but not included within the definition of "Implants" are not subject to the Implant Maximum.]

- **[Limitations on Dental Accident Benefits:**

- (1) The dental accident must occur while the Enrollee is covered under this Contract.
- (2) Services and procedures must be provided within 180 days following the dental accident and while the Enrollee is covered under this Contract.]

#### 4.07 Exclusions

**Delta Dental does not pay Benefits for:**

- treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.
- maxillofacial prosthetics.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- any Single Procedure started prior to the date the Enrollee became eligible for services under this program.
- prescribed drugs, medication, pain killers, antimicrobial agents, or experimental procedures.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- fixed bridges and removable partials for enrollees under age 16.
- interim implants.
- resin-based inlays and onlays.
- overdentures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- services or supplies covered by any other health plan of the Contractholder.
- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [the initial placement of any prosthodontic appliance [or implants], unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Contract or was covered under [any dental care program with Delta Dental / the Contractholder's prior dental plan]. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.]

- services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefit section, if applicable.
- procedures performed for the purpose of orthodontic treatment except as provided under Orthodontic Benefits, if applicable.
- services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ) except as provided under the TMJ Benefit section, if applicable.
- [services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.]
- [services not included on the Table of Allowances.]
- [services or supplies for oral surgery, general anesthesia or IV sedation, palliative treatment, or sealants.]
- [services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).]
- [services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
- [services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- [services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.]
- [services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).

## **ARTICLE 5**

### **DEDUCTIBLE, MAXIMUM AND COORDINATION OF BENEFITS**

#### **5.01 Deductible**

[As shown on Appendix A, Delta Dental will not pay Benefits for the Deductible amount of the Maximum Contract Allowance for services received each [Contract/Calendar] Year by an Enrollee. The annual maximum Deductible per family, if any, is shown in Appendix A. Only fees an Enrollee pays for services that are described under Article 4 will count toward the Deductible.]

[Delta Dental will not pay Benefits for the Deductible amount shown in Appendix A of the Maximum Contract Allowance for services received until the lifetime Deductible has been satisfied by the Enrollee while covered under a Delta Dental plan. Only fees an Enrollee pays for services that are described under Article 4 will count toward the Deductible.

#### **5.02 Maximum**

Delta Dental will pay the maximum amount(s) shown in Appendix A for Benefits under this Contract.

#### **5.03 Coordination of Benefits**

[Delta Dental coordinates the Benefits under this Contract with an Enrollee's Benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. Benefits under one of the plans may be reduced so that combined coverage does not exceed the Provider's total fees for covered services. If this is the "primary" plan, Delta Dental will not reduce Benefits, but if the other Plan is the primary one, Delta Dental will reduce Benefits otherwise payable under this Contract. The reduction will be the amount paid for or provided under the terms of the primary plan for covered services under Article 4.]

[Delta Dental coordinates the Benefits under this Contract with an Enrollee's Benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. Benefits under this plan may be reduced so that combined coverage does not exceed Delta Dental's Maximum Contract Allowance. If this is the "primary" plan, Delta Dental will not reduce Benefits, but if the other Plan is the primary one, Delta Dental will reduce Benefits otherwise payable under this Contract. The reduction will be the amount paid for or provided under the terms of the primary plan for covered services under Article 4.]

#### *Order of Benefit Determination Rules:*

The following rules determine which plan is the “primary” plan:

- If the other Plan is not primarily a dental plan, this Plan is primary, except the Enrollee’s medical plan, if any, will be primary for oral surgery procedures covered under such plan.
- If the other Plan is a dental plan, the following rules are applied:
  - (1) The Plan covering the Enrollee as an employee is primary over a Plan covering the Enrollee as a dependent.
  - (2) The Plan covering the Enrollee as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - a) Secondary to the Plan covering the insured person as a dependent and
    - b) Primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the Benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
  - (3) Except as stated in paragraph (4), when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    - a) The Benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the Benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
  - (4) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent’s spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the Benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the Benefits of any other policy which covers the child as a dependent child.
  - (5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).
  - (6) The Benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this Rule (6) is ignored.
  - (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
    - a) First, the Benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person’s dependent);
    - b) Second, the Benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored.
  - (8) If none of the above rules determine the order of Benefits, the Benefits of the Plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

### **ARTICLE 6 CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED**

#### **6.01 Choice of a Provider**

Enrollees may choose a Provider from Delta Dental’s panel of PPO and Premier Providers or Enrollees may choose a Non-Delta Dental Provider. A list of PPO and Premier Providers can be obtained by accessing the Delta Dental National Dentist Directory at [www.deltadentalins.com](http://www.deltadentalins.com). Enrollees are responsible for verifying whether the selected Provider is a PPO Provider or a Premier Provider. Providers are regularly added to the panel. Additionally, Enrollees should always confirm with the Provider’s office that a listed Provider is still a participating PPO Provider or Premier Provider

#### *PPO Provider*

The PPO program potentially allows the greatest reduction in Enrollees’ out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

#### *Premier Provider*

The Premier Provider, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if Enrollees use a Non-Delta Dental Dentist

#### *Non-Delta Dental Provider*

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by the PPO Providers or Premier Providers. For a Non-Delta Dental Provider, the Accepted Fee is the Provider’s submitted charge.

*Additional advantages of using a Delta Dental Provider:*

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider has contractually agreed to charge no more than his/her Delta Dental Provider's Contracted Fee even for services that are not covered under this Contract provided the service(s) are included in his/her agreement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

An Enrollee may also access Delta Dental's Provider Directory on the Internet. Delta Dental's Internet address is [www.deltadentalins.com](http://www.deltadentalins.com). An Enrollee may choose any Provider, but Delta Dental does not guarantee that any particular Provider will be available. The Enrollee is responsible for verifying whether the treating Provider is a PPO or Premier Provider.

**6.02 Clinical Examination**

Before approving a claim, Delta Dental may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Delta Dental may require to administer the claim. Delta Dental may also require that an Enrollee be examined by a dental consultant retained by Delta Dental in or near his/her community or residence. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

**6.03 Notice of Claim Forms**

Delta Dental will furnish to any Provider or Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the form must be completed and signed by the Provider who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Delta Dental at the address shown thereon. If Delta Dental does not furnish the form within 15 days after requested by a Provider or Enrollee, the requirements for proof of loss set forth in section 6.05 of this Contract will be deemed to have been complied with upon the submission to Delta Dental within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Enrollees may download a Claim Form from Delta Dental's web site.

**6.04 Pre-Treatment Estimate**

A Provider may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

**6.05 Written Notice of Claim/Proof of Loss**

Delta Dental must be given written proof of loss within [12 months] after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within [12] months of the termination of this Contract.

**6.06 Time of Payment**

Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Delta Dental will notify the Primary Enrollee and his/her Provider of any additional information needed to process the claim within this 30day period.

**6.07 Claims Appeal**

Delta Dental's commitment to the Enrollee is to ensure quality throughout the entire dental benefit process: from the courtesy extended to the Enrollee by our Customer Service Representatives to the dental services provided by Premier and PPO Providers. If the Enrollee has questions about any services received, we recommend that the Enrollee first discusses the matter with his/her Provider. However, if the Enrollee continues to have concerns, they should call our Customer Service Center. The Enrollee can also e-mail questions by accessing the "Contact Us" section of our web site at [www.deltadentalins.com](http://www.deltadentalins.com).

Complaints or Appeals regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 800-521-2651.

When the Enrollee writes, he/she should include the name of the Enrollee, the Primary Enrollee's name and ID number, and their telephone number on all correspondence. The Enrollee should also include a copy of the claim



form, claim statement, or other relevant information. The claim statement will have an explanation of the claim review and any complaint or appeal process and time limits applicable to such process.

Delta Dental will notify the Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee and his/her Provider have at least 180 days after receiving a notice of denial to request a review by writing to Delta Dental giving reasons why they believe the denial was wrong. The Enrollee and his/her Provider may also ask Delta Dental to examine any additional information provided that may support the complaint or appeal.

Send your complaint or appeal to Delta Dental at the address shown below:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023

Delta Dental will send the Enrollee a written acknowledgment within 5 days upon receipt of the [complaint] [grievance] or appeal. Delta Dental will make a full and fair review within 30 days after we receive the [complaint] [grievance] or appeal. Delta Dental may ask for more documents if needed. Delta Dental will send the Enrollee a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Delta Dental shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If the Enrollee believes he/she needs further review of their [complaint] [grievance] or appeal, he/she may [file a request with us for a second level review or] contact his/her state insurance regulatory agency.

#### **6.08 To Whom Benefits Are Paid**

Payment for services provided by a PPO Provider or a Premier Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Primary Enrollee.. All Benefits not paid to the Provider will be payable to the Primary Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

### **ARTICLE 7 GENERAL PROVISIONS**

#### **7.01 Entire Contract: Changes**

This Contract, including the Application and the attachments listed in Article 9, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Delta Dental.

#### **7.02 Severability**

If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract will remain in full force and effect.

#### **7.03 Conformity With State Laws**

All legal questions about this Contract will be governed by the state of Arkansas where this Contract was entered into and is to be performed. Any part of this Contract which, on its Effective Date, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.

#### **7.04 Misstatements on Application; Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

#### **7.05 Legal Actions**

No action at law or in equity will be brought to recover on this Contract before 60 days after proof of loss has been filed in accordance with requirements of this Contract; nor will an action be brought after the expiration of three (3) years after the time written proof is required to be furnished.

#### **7.06 Not in Lieu of Workers' Compensation**

This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

**7.07 Certificate of Insurance**

[Delta Dental will issue to the Contractholder for delivery to each Primary Enrollee a certificate/Evidence of Coverage booklet summarizing the Benefits to which they are entitled and to whom Benefits are payable.] [Delta Dental will issue to the Contractholder an electronic file containing a certificate/Evidence of Coverage booklet summarizing the Benefits to which Enrollees are entitled and to whom Benefits are payable. Each Primary Enrollee will have electronic access to the certificate.] The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or riders showing the change will be issued.

**7.08 Publications About Program**

Contractholder and Delta Dental agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

**7.09 Professional Relationship**

Contractholder and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference.

**7.10 Notice; Where Directed**

All formal notice under this Contract must be in writing and sent by first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.

**[7.11 Indemnification**

Contractholder will indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Delta Dental will indemnify, defend and hold harmless Contractholder and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Agreement.]

**7.12 Time Limit On Certain Defenses**

After this Contract has been in force for three (3) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Enrollee with respect to the Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect three (3) years or more during his or her lifetime.

**7.13 Compliance with Administrative Simplification, Security and Privacy Regulations**

Contractholder shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information. The Contractholder agrees that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

**7.14 Impossibility of Performance**

Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

**7.15 Third Party Administrator (TPA)**

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Delta Dental providing that the TPA shall meet HIPAA requirements for the preservation of protected health information of Enrollees.

**[7.16 Eligibility Update Through Delta Dental's Website**

Contractholder agrees to be responsible for any and all hardware, software or any other equipment, application or transmission capability to access the Delta Dental web site, including its Internet Access Provider (IAP) or Internet Service Provider (ISP). Contractholder will hold Delta Dental and its parent company, which provides computer processing services, harmless for any and all transmission or update delays, failures or errors caused by Contractholder's acts or omissions or caused by the ISP's acts or omissions. Contractholder agrees to hold Delta Dental and its parent company harmless for any and all potential breaches of confidentiality resulting from or arising out of the transmission or update of Enrollee eligibility information through Internet connections. Contractholder shall indemnify Delta Dental and its parent company from and against any liability or loss Delta Dental or its parent company may incur by reason of any covenant, condition or warranty contained in this Contract relating to confidentiality or the interception of

transmission over the Internet by unknown third parties except for any breach caused by Delta Dental's or its parent company's error or omission.]

## **ARTICLE 8 TERMINATION AND RENEWAL,**

- 8.01 This Contract may be terminated only as follows:
- [By Contractholder upon [(60)] days written notice.]
  - By Delta Dental,
    - (1) upon [(60)] days written notice if Contractholder fails to furnish Delta Dental a list of all Enrollees as required under section 2.01; or
    - (2) upon [(60)] days written notice if Contractholder fails to permit Delta Dental to inspect Contractholder's records as called for under section 2.02; or
    - (3) upon [(31)] days written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
  - By Delta Dental, if Contractholder reports fewer than the Minimum Number of Primary Enrollees shown in Appendix A for three (3) consecutive months. Delta Dental must give Contractholder notice within 15 days after receiving the list of Primary Employees which shows that Delta Dental may terminate on this basis.
  - By Delta Dental at the end of a Contract Term upon 60 days written notice.
- 8.02 In the event this Contract is terminated under Section 8.01 second bullet item, Contractholder will become immediately obligated upon termination to pay Delta Dental for that portion of the monthly Premium which constitutes for the current Contract Term Delta Dental's direct costs of administering this Contract (calculated by subtracting the pure Premium from the total Premium) multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25 percent of the total Premium for the entire Contract Term.
- 8.03 If Contractholder notifies Delta Dental that it intends to terminate this Contract upon less than 60 days notice, Section 8.02 will apply as if Delta Dental terminated this Contract under Section 8.01 second bullet.
- 8.04 Delta Dental will not be required to do Pre-treatment Estimates if this Contract is terminated for any cause nor will Delta Dental be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect.
- 8.05 Delta Dental will provide [60] days advance written renewal notice prior to the end of the initial or any subsequent Contract Terms indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Delta Dental of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Delta Dental will terminate this Contract under 8.01 second bullet, item (3).

## **ARTICLE 9 ATTACHMENTS**

These documents are attached to this Contract and made a part of it:

**Appendix A      Group Policy Schedule**  
**Appendix B      Arkansas Life and Health Insurance Guaranty Association Act**  
**[Appendix C      Table of Allowances]**  
**Copy of Application**  
**[Appendix to the Application]**

**APPENDIX A**  
**GROUP POLICY SCHEDULE**  
*[Information in this section is variable.]*

**Contractholder Name:**

**Address:**

**Group Number:**

**Effective Date:**

**Contract Term:**

**Benefits:**

	<i>Contract Benefit Level</i>		
	<i>In-Network</i>	<i>Out-of-Network</i>	
	<i>PPO</i>	<i>Premier</i>	<i>Non-Delta Dental</i>
Diagnostic and Preventive Benefits:	%	%	%
[Basic Benefits:]	%	%	%
[Major Benefits:]	%	%	%
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%
[Implant Benefits:]	%	%	%
[Dental Accident Benefits:]	%	%	%

[Delta Dental will pay or otherwise discharge the Maximum Contract Allowance up to the amounts shown on the Table of Allowances, for Diagnostic and Preventive, Basic, Major, Implant and Dental Accident Benefits. However, Delta Dental will pay a percentage of the Maximum Contract Allowance for the following services:

	<i>Contract Benefit Level</i>		
	<i>In-Network</i>	<i>Out-of-Network</i>	
	<i>PPO</i>	<i>Premier</i>	<i>Non-Delta Dental</i>
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%

**[Late Entrants:** Benefits for Late Entrants are limited until they have been enrolled in this Contract for [12] consecutive months.]

	<i>Contract Benefit Level</i>		
	<i>In-Network</i>	<i>Out-of-Network</i>	
	<i>PPO</i>	<i>Premier</i>	<i>Non-Delta Dental</i>
Diagnostic and Preventive Benefits:	%	%	%
[Basic Benefits:]	%	%	%
[Major Benefits:]	%	%	%
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%
[Implant Benefits:]	%	%	%
[Dental Accident Benefits:]	%	%	%

**Waiting Periods:**

- [[Basic Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Basic Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Major Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Major Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Orthodontic Benefits are limited to [dependent children of Primary Enrollees] [Primary Enrollees and their Dependent Enrollees] who have been enrolled in this Contract for [12] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Orthodontic Benefits are limited to [dependent children of Primary Enrollees] [Primary Enrollees and their Dependent Enrollees] who have been enrolled in this Contract for [12] consecutive months. The waiting period for a Dependent

Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]

- [[TMJ Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[TMJ Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Implant Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Implant Benefits are limited to Enrollees who have been enrolled in this Contract for [12] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]

**Deductible Amount:**

For each Enrollee per [Contract/Calendar Year]:       \$.  
For each family per [Contract/Calendar Year]:       \$.  
[Lifetime Deductible per Enrollee: \$\_\_\_\_\_]

[Orthodontic Benefits are subject to a separate Deductible of \$ [per Enrollee/per dependent child Enrollee] per [Calendar/Contract Year/ lifetime]

[TMJ Benefits are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

[Implant Benefits are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

[The Deductible does not apply to Diagnostic and Preventive Services [or Orthodontic/TMJ/Implant Services.]

[Any Deductible amount satisfied by the Enrollee during the last three (3) months of the year will be applied toward the Deductible for the following year.]

**[Deductible Takeover Credit:**

[Any Deductible satisfied by the Enrollees under the Contractholder's prior plan from January 1st to the Effective Date will be credited towards the Deductible under this Contract.]

[Any Deductible satisfied by the Enrollees for [Orthodontic, TMJ or Implant Benefits] under the Contractholder's prior plan from January 1, 200\_\_to the Effective Date will be credited towards the Deductible under this plan.]

[Delta Dental will receive credit for any lifetime [Orthodontic, TMJ or Implant] Deductible amounts satisfied under the Contractholder's previous dental care plan.]]

**Maximum Amount:**

\$                   per Enrollee per [Contract/Calendar Year.].]  
[                   per [[Enrollee/dependent child Enrollee] per [lifetime/Calendar/ContractYear] for Orthodontic Benefits.]  
\$  
[                   [per Enrollee per lifetime for TMJ Benefits.]  
\$  
[                   [per Enrollee per lifetime for Implant Benefits.]  
\$  
[                   [per Enrollee each [Contract/Calendar Year. For Dental Accident Benefits]

[The Maximum Amount does not apply to Diagnostic and Preventive Benefits.]

[Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care plan from January 1<sup>st</sup> to the Effective Date. These amounts will be credited towards the Calendar Year Maximum.]

Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care Contract, if applicable, for [Orthodontic/TMJ/Implant Benefits]. These amounts will be credited towards the maximum amounts payable for [Orthodontic/TMJ/Implant Benefits.]

**Termination:**

[Less than 10 Primary Enrollees.]

[A [30%] reduction in the number of Primary Enrollees over three (3) consecutive months.]

**Premiums:****Monthly Amount:**

[Per Primary Enrollee:	\$
Per Primary Enrollee and his/her Dependent Enrollees:]	\$
 [Per Primary Enrollee:	 \$
Per Primary Enrollee with one Dependent Enrollee:	\$
Per Primary Enrollee with two or more Dependent Enrollees:]	\$
 [Per Primary Enrollee:	 \$
Per Primary Enrollee and Spouse:	\$
Per Primary Enrollee and Child(ren):	\$
Per Primary Enrollee and Family:]	\$

***Premiums are to be remitted to:***

Delta Dental Insurance Company  
P. O. Box 1809  
Alpharetta, GA 30022-1809

**Payment Breakdown:**

Contractholder shall pay:	%	for Primary Enrollee
	%	for Dependent Enrollees
 Primary Enrollee shall pay:	 %	 for Primary Enrollee
	%	for Dependent Enrollees

[Delta Dental shall receive a full month's Premium for all Enrollees.]

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

**APPENDIX B**  
**LIMITATIONS AND EXCLUSIONS UNDER THE**  
**ARKANSAS LIFE AND HEALTH INSURANCE**  
**GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverage’s, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state).
- The insurer was not authorized to do business in this state.
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to groups contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plan protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an allocated annuity contract now owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution );
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligation that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

## LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guarantee Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 –no matter how many policies and contracts there were with the same company, even if they provided different types of coverage's. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage's. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



**APPENDIX C**  
**Dentegra Insurance Company**  
**TABLE OF ALLOWANCES**

<b>PROCEDURE NUMBER</b>	<b>PROCEDURE DESCRIPTION</b>	<b>TABLE OF ALLOWANCE</b>
<b><u>Clinical Oral Evaluations</u></b>		
D0120	Periodic oral evaluation - established patient.....	26.00
D0140	Limited oral evaluation - problem focused .....	42.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	26.00
D0150	Comprehensive oral evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
D0160	Detailed and extensive oral evaluation - problem focused, by report <i>(limited to one per Provider all subsequent ones will be benefited as D0120)</i> .....	56.00
D0180	Comprehensive periodontal evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
<b><u>Radiographs/Diagnostic Imaging</u></b> (Including Interpretation) <i>(Any combination of bitewings, periapicals and panoramic films taken on the same day will be combined as a complete series when the fees are equal to or exceed that of a complete series)</i>		
D0210	Intraoral - complete series (including bitewings).....	78.00
D0220	Intraoral - periapical - first film.....	16.00
D0230	Intraoral - periapical - each additional film.....	12.00
D0240	Intraoral occlusal film .....	19.00
D0250	Extraoral - first film.....	19.00
D0260	Extraoral - each additional film.....	14.00
D0272	Bitewings - two films .....	25.00
D0273	Bitewings - three films .....	34.00
D0274	Bitewings - four films .....	43.00
D0277	Vertical bitewings - seven to eight films.....	53.00
D0330	Panoramic film.....	70.00
D0340	Cephalometric film <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	70.00
D0350	Oral/facial photographic images <i>(This is a benefit only once per case in conjunction with orthodontic services)</i> .....	42.00
<b><u>Test and Examinations</u></b>		
D0470	Diagnostic casts <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	54.00
<b><u>Dental Prophylaxis</u></b>		
D1110	Prophylaxis - adult .....	54.00
D1120	Prophylaxis - child <i>(to age 14)</i> .....	43.00
<b><u>Topical Fluoride - (Office Procedure)</u></b>		
D1203	Topical Application of fluoride - child <i>(through age 13)</i> .....	22.00
D1204	Topical Application of fluoride - adult <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
D1206	Topical fluoride varnish; therapeutic Application for moderate to high caries risk patients <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
<b><u>Other Preventive Services</u></b>		
D1351	Sealant - per tooth .....	28.00
	<i>(benefit to permanent first molars through age 8 and second molars through age 15)</i>	
<b><u>Space Maintainers (Passive Appliances)</u></b>		
D1510	Space maintainers – fixed, unilateral .....	202.00
D1515	Space maintainers – fixed, bilateral .....	310.00
D1520	Space maintainers – removable, unilateral.....	256.00
D1525	Space maintainers – removable, bilateral.....	287.00
D1555	Removal of fixed space maintainer .....	50.00
<b><u>Amalgam Restorations (Including Polishing)</u></b> <i>(the fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp cap, local anesthesia, polishing, occlusal adjustment, caries, removal and gingivectomy on the same date of service. Replacement of restorations by the same Provider is a benefit after 24 months)</i>		
D2140	Amalgam - one surface, primary or permanent.....	59.00
D2150	Amalgam - two surfaces, primary or permanent .....	78.00
D2160	Amalgam - three surfaces, primary or permanent .....	93.00
D2161	Amalgam - four or more surfaces, primary or permanent.....	109.00
<b><u>Resin-Based Composite Restorations-Direct</u></b>		
D2330	Resin-based composite - one surface, anterior.....	71.00
D2331	Resin-based composite - two surface, anterior.....	87.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D2332	Resin-based composite - three surfaces, anterior .....	109.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).....	135.00
D2391	Resin-based composite - one surface, posterior .....	59.00
D2392	Resin-based composite - two surfaces, posterior .....	78.00
D2393	Resin-based composite - three surfaces, posterior .....	93.00
D2394	Resin-based composite - four or more surfaces, posterior .....	171.00

*Fees for Cast Restorations should include tooth preparation, pulp capping, laboratory costs, temporary restorations, porcelain margins, cement bases, routine buildup/substructure, impressions, local anesthesia, occlusal correction, preparation of the gingival tissue and any recementation or repair within six months.*

#### **Inlay/Onlay Restorations**

D2510	Inlay - metallic - one surface .....	233.00
D2520	Inlay - metallic - two surfaces .....	271.00
D2530	Inlay - metallic - three or more surfaces.....	305.00
D2542	Onlay - metallic - two surfaces.....	353.00
D2543	Onlay - metallic - three surfaces.....	377.00
D2544	Onlay - metallic - four or more surfaces .....	394.00
D2610	Inlay - porcelain/ceramic - one surface .....	233.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	271.00
D2630	Inlay - porcelain/ceramic - three or more surfaces .....	305.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	353.00
D2643	Onlay - porcelain/ceramic - three surfaces.....	377.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.....	394.00

#### **Crowns-Single Restorations Only**

D2740	Crown - porcelain/ceramic substrate .....	375.00
D2750	Crown - porcelain fused to high noble metal .....	383.00
D2751	Crown - porcelain fused to predominantly base metal .....	341.00
D2752	Crown - porcelain fused to noble metal .....	357.00
D2780	Crown - cast 3/4 high noble metal .....	395.00
D2781	Crown - cast 3/4 predominantly base metal .....	372.00
D2782	Crown - cast 3/4 noble metal.....	386.00
D2783	Crown - cast 3/4 porcelain/ceramic.....	405.00
D2790	Crown - full cast high noble metal .....	372.00
D2791	Crown - full cast predominantly base metal .....	330.00
D2792	Crown - full cast noble metal .....	349.00
D2794	Crown - titanium .....	372.00

#### **Other Restorative Services**

D2910	Recement inlay, onlay, or partial coverage restoration .....	28.00
D2915	Recement cast or prefabricated post and core .....	28.00
D2920	Recement crown .....	28.00
D2930	Prefabricated stainless steel crown - primary tooth.....	136.00
D2931	Prefabricated stainless steel crown - permanent tooth .....	98.00
D2932	Prefabricated resin crown .....	98.00
D2933	Prefabricated stainless steel crown with resin window .....	B/R*
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth .....	B/R*
D2940	Sedative Filling .....	50.00
D2950	Core build-up, including any pins ( <i>considered part of crown fee except in exceptional circumstances or for endodontically treated teeth</i> ).....	78.00
D2951	Pin retention - per tooth, in addition to restoration .....	28.00
D2952	Post and core in addition to crown, indirectly fabricated.....	116.00
D2954	Prefabricated post and core in addition to crown .....	98.00
D2960	Labial veneer (resin laminate) - chairside .....	147.00
D2961	Labial veneer (resin laminate) - laboratory .....	233.00
D2962	Labial veneer (porcelain laminate) - laboratory .....	299.00
D2971	Additional procedures to construct new crown under existing partial denture framework.....	B/R*
D2980	Crown repair.....	B/R*

#### **Pulpotomy**

D3220	Therapeutic pulpotomy (excluding final restoration).....	81.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .....	81.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Endodontic Therapy</u></b> (Including treatment plan, clinical procedures and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration) .....	350.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration) .....	415.00
D3330	Endodontic therapy, molar (excluding final restoration) .....	527.00
<b><u>Endodontic Retreatment</u></b>		
<i>Retreatment of root canal therapy within 24 months of the initial procedure is included in the original contracted fee when performed by the same Provider or in the original submitted fee when performed by an out-of-network Provider.</i>		
D3346	Retreatment of previous root canal therapy - anterior.....	419.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	496.00
D3348	Retreatment of previous root canal therapy - molar .....	605.00
<b><u>Apexification/Recalcification Procedures</u></b>		
D3351	Apexification/recalcification - initial visit.....	225.00
D3352	Apexification/recalcification - interim medication replacement .....	98.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy) .....	332.00
<b><u>Apicoectomy/Periradicular Services</u></b>		
D3410	Apicoectomy/periradicular surgery - anterior .....	273.00
D3421	Apicoectomy/periradicular surgery - bicuspid - (first root) .....	341.00
D3425	Apicoectomy/periradicular surgery - molar - (first root) .....	400.00
D3426	Apicoectomy/periradicular surgery - (each additional root) .....	124.00
D3430	Retrograde filling - per root .....	81.00
D3450	Root amputation - per root .....	186.00
<b><u>Other Endodontic Procedures</u></b>		
D3920	Hemisection (including any root removal), not including root canal therapy .....	186.00
<b><u>Surgical Services (Including usual postoperative care)</u></b>		
<i>On periodontal surgical procedures, the surgery is considered to include any surgical re-entry or scaling and root planing for three years.</i>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.....	245.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.....	87.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.....	310.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.....	186.00
D4249	Clinical crown lengthening - hard tissue .....	B/R*
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.....	451.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	270.00
D4270	Pedicle soft tissue graft procedure (limited to two sites per quadrant) .....	341.00
D4271	Free soft tissue graft procedure (including donor site surgery) (limited to two sites per quadrant) .....	391.00
<b><u>Non-Surgical Periodontal Service</u></b>		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	124.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant .....	74.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis .....	54.00
<b><u>Other Periodontal Services</u></b>		
D4910	Periodontal maintenance procedure .....	68.00
<b><u>Complete Dentures</u></b> (Includes routine post delivery care and relining for the first six months after placement)		
D5110	Complete denture - maxillary.....	426.00
D5120	Complete denture - mandibular.....	426.00
D5130	Immediate denture - maxillary .....	465.00
D5140	Immediate denture - mandibular .....	465.00
<b><u>Partial Dentures</u></b> (Includes routine post delivery care for the first six months after placement)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) .....	295.00
D5212	Mandibular partial denture -resin base (including any conventional clasps, rests and teeth) .....	295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	378.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	378.00
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) .....	310.00
<b><u>Adjustment to Dentures</u></b>		
D5410	Adjust complete denture - maxillary .....	37.00
D5411	Adjust complete denture - mandibular .....	37.00
D5421	Adjust partial denture - maxillary .....	37.00
D5422	Adjust partial denture - mandibular .....	37.00
<b><u>Repairs to Complete Dentures</u></b>		
D5510	Repair broken complete denture base .....	81.00
D5520	Replace missing broken tooth - complete denture (each tooth) .....	74.00
<b><u>Repairs to Partial Dentures</u></b>		
D5610	Repair resin denture base .....	81.00
D5620	Repair cast framework .....	115.00
D5630	Repair or replace broken clasp .....	109.00
D5640	Replace broken teeth - per tooth .....	74.00
D5650	Add tooth to existing partial denture.....	96.00
D5660	Add clasp to existing partial denture.....	109.00
<b><u>Denture Rebase Procedures</u></b> (Any rebase includes relining and any adjustments for six months following placement. One rebase per arch is covered in a 24 month period)		
D5710	Rebase complete maxillary denture.....	248.00
D5711	Rebase complete mandibular denture.....	248.00
D5720	Rebase maxillary partial denture .....	223.00
D5721	Rebase mandibular partial denture .....	223.00
<b><u>Denture Reline Procedures</u></b>		
D5730	Reline complete maxillary denture (chairside).....	144.00
D5731	Reline complete mandibular denture (chairside).....	144.00
D5740	Reline maxillary partial denture (chairside) .....	136.00
D5741	Reline mandibular partial denture (chairside) .....	136.00
D5750	Reline complete maxillary denture (laboratory).....	217.00
D5751	Reline complete mandibular denture (laboratory).....	217.00
D5760	Reline maxillary partial denture (laboratory) .....	205.00
D5761	Reline mandibular partial denture (laboratory) .....	205.00
<b><u>Interim Prosthesis</u></b>		
D5820	Interim partial denture - maxillary .....	175.00
D5821	Interim partial denture - mandibular .....	175.00
<b><u>Other Removable Prosthetic Services</u></b>		
D5850	Tissue conditioning - maxillary.....	47.00
D5851	Tissue conditioning - mandibular.....	47.00
<b><u>Maxillofacial Prosthetics</u></b>		
D5900-5999 Maxillofacial prosthetic procedures are generally not benefits of Delta Dental programs. When covered, they follow the benefits required under state regulatory guidelines, and typically are limited to services provided to newborn, dependent children for medically diagnosed congenital defects, birth abnormalities.		
<b><u>Implant Services</u></b>		
<b><u>Pre-Surgical Services</u></b>		
D6190	Radiographic/surgical implant index.....	B/R*
<b><u>Surgical Services</u></b>		
D6010	Surgical placement of implant body: endosteal implant .....	0.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant..... (Delta Dental considers this procedure part of the transitional prosthesis which is not a covered benefit)	0.00

D6040	Surgical placement: eposteal implant.....	0.00
D6050	Surgical placement: transosteal implant.....	0.00
<b>PROCEDURE NUMBER</b>	<b>PROCEDURE DESCRIPTION</b>	<b>TABLE OF ALLOWANCE</b>
<b><u>Implant Supported Prosthetics</u></b>		
<b><u>Supporting Structures</u></b>		
D6055	Dental implant supported connecting bar.....	0.00
D5212	Mandibular abutment — includes placement.....	0.00
D6056	Prefabricated abutment — includes placement .....	0.00
D6057	Custom abutment — includes placement .....	0.00
<b><u>Implant/Abutment Supported Removable Dentures</u></b>		
D6053	Implant/abutment supported removable denture for completely edentulous arch.....	0.00
D6054	Implant/abutment supported removable denture for partially edentulous arch .....	0.00
<b><u>Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)</u></b>		
D6078	Implant/abutment supported fixed denture for completely edentulous arch .....	0.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.....	0.00
<b><u>Single Crowns, Abutment Supported</u></b>		
D6058	Abutment supported porcelain/ceramic crown.....	0.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	0.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	0.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	0.00
D6062	Abutment supported cast metal crown (high noble metal).....	0.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	0.00
D6064	Abutment supported cast metal crown (noble metal).....	0.00
D6094	Abutment supported crown — (titanium) .....	0.00
<b><u>Single Crowns, Implant Supported</u></b>		
D6065	Implant supported porcelain/ceramic crown .....	0.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).....	0.00
D6067	Implant supported metal crown (titanium, titanium alloy, noble metal) .....	0.00
<b><u>Fixed Partial Denture, Abutment Supported</u></b>		
D6068	Abutment supported retainer for porcelain/ceramic FPD .....	0.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	0.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).....	0.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	0.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).....	0.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal) .....	0.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).....	0.00
D6194	Abutment supported retainer crown for FPD — (titanium) .....	0.00
<b><u>Fixed Partial Denture, Implant Supported</u></b>		
D6075	Implant supported retainer for ceramic FPD .....	0.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) ..	0.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal).....	0.00
<b><u>Other Implant Services</u></b>		
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis .....	0.00
D6090	Repair implant supported prosthesis .....	B/R*
D6095	Repair implant abutment .....	B/R*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment..... <i>(D6091 is a benefit only after the prosthodontic time limitation (usually 5 years) has elapsed since the implant attachment was placed)</i>	0.00
D6092	Recent implant/abutment supported crown .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6093	Recent implant/abutment supported fixed partial denture .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6094	CDT coding places procedure D6094 immediately following D6064 .....	0.00
D6190	CDT coding places procedure D6190 immediately before D6010 .....	0.00
D6194	CDT coding places procedure D6194 immediately following D6074 .....	0.00
D6199	Unspecified implant procedure .....	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Fixed Partial Denture Pontics</u></b>		
D6205	Pontic - indirect resin based composite .....	332.00
D6210	Pontic - cast high noble metal .....	370.00
D6211	Pontic - cast predominantly base metal .....	332.00
D6212	Pontic - cast noble metal .....	357.00
D6214	Pontic - titanium .....	370.00
D6240	Pontic - porcelain fused to high noble metal .....	369.00
D6241	Pontic - porcelain fused to predominantly base metal .....	346.00
D6242	Pontic - porcelain fused to noble metal .....	353.00
<b><u>Fixed Partial Denture Retainers—Inlays/Onlays</u></b>		
D6545	Retainer - cast metal for resin bonded fixed prosthesis .....	155.00
D6600	Inlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6602 will be given</i> ) .....	260.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6603 will be given</i> ) .....	302.00
D6602	Inlay - cast high noble metal, two surfaces .....	260.00
D6603	Inlay - cast high noble metal, three or more surfaces .....	302.00
D6604	Inlay - cast predominately base metal, two surfaces .....	260.00
D6605	Inlay - cast predominately base metal, three or more surfaces .....	302.00
D6606	Inlay - cast noble metal, two surfaces .....	260.00
D6607	Inlay - cast noble metal, three or more surfaces .....	302.00
D6608	Onlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6610 will be given</i> ) .....	361.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6611 will be given</i> ) .....	388.00
D6610	Onlay - cast high noble metal, two surfaces .....	361.00
D6611	Onlay - cast high noble metal, three or more surfaces .....	388.00
D6612	Onlay - cast predominately base metal, two surfaces .....	361.00
D6613	Onlay - cast predominately base metal, three or more surfaces .....	388.00
D6614	Onlay - cast noble metal, two surfaces .....	361.00
D6615	Onlay - porcelain/ceramic, three or more surfaces .....	388.00
D6624	Inlay - titanium .....	302.00
D6634	Onlay - titanium .....	388.00
<b><u>Fixed Partial Denture Retainers—Crowns</u></b>		
D6710	Crown - indirect resin based composite .....	B/R*
D6750	Crown - porcelain fused to high noble metal .....	383.00
D6751	Crown - porcelain fused to predominantly base metal .....	341.00
D6752	Crown - porcelain fused to noble metal .....	357.00
D6780	Crown - 3/4 cast high noble metal .....	395.00
D6781	Crown - 3/4 cast predominantly base metal .....	372.00
D6782	Crown - 3/4 cast noble metal .....	386.00
D6783	Crown - 3/4 cast porcelain/ceramic ( <i>an alternate benefit of D6780 will be given</i> ) .....	405.00
D6790	Crown - full cast high noble metal .....	372.00
D6791	Crown - full cast predominantly base metal .....	330.00
D6792	Crown - full cast noble metal .....	349.00
D6794	Crown - titanium .....	378.00
<b><u>Other Fixed Partial Denture Services</u></b>		
D6930	Recement fixed partial denture .....	39.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated .....	124.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer .....	98.00
D6973	Core buildup for retainer, including any pins .....	96.00
D6980	Fixed partial denture repair .....	B/R*
<b><u>Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7140	Extraction, erupted tooth or exposed root (elevation &/or forceps removal) .....	62.00
<b><u>Surgical Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7210	Surgical removal of erupted tooth .....	118.00
D7220	Removal of impacted tooth - soft tissue .....	155.00
D7230	Removal of impacted tooth - partially bony .....	205.00
D7240	Removal of impacted tooth - completely bony .....	242.00
D7250	Surgical removal of residual tooth roots (cutting procedure) .....	118.00
<b><u>Other Surgical Procedures</u></b>		
D7280	Surgical access of an unerupted tooth .....	155.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	B/R*
D7285	Biopsy of oral tissue - hard (bone, teeth) .....	158.00
D7286	Biopsy of oral tissue - soft .....	118.00

D7290 Surgical repositioning of teeth ..... B/R\*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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**Alveoloplasty – Surgical Preparation of Ridge**

D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	121.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	73.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ( <i>usually in preparation for prosthesis</i> ).....	167.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	101.00

**Vestibuloplasty**

D7340	Vestibuloplasty - ridge extension - (secondary epithelialization) .....	161.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachments and management of hypertrophied and hyper plastic tissue) .....	326.00

**Surgical Excision of Soft Tissue Lesions**

D7410	Excision of benign lesion to 1.25 cm .....	B/R*
D7411	Excision of benign lesion diameter greater than 1.25 cm .....	B/R*
D7412	Excision of benign lesion complicated.....	B/R*
D7413	Excision of malignant lesion, up to 1.25 cm .....	B/R*
D7414	Excision of malignant lesion greater than 1.25 .....	B/R*
D7415	Excision of malignant lesion, complicated.....	B/R*

**Surgical Excision of Intra-Osseous Lesions**

D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm .....	B/R*
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.....	B/R*
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25 cm.....	B/R*
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7460	Removal of benign nonodontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7461	Removal of benign nonodontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7465	Destruction of lesion(s) by physical or chemical methods.....	B/R*

**Excision of Bone Tissue**

D7471	Removal of lateral exostosis (maxilla or mandible).....	524.00
D7472	Removal of torus palatinus.....	524.00
D7473	Removal of torus mandibularis .....	524.00

**Surgical Incision**

D7510	Incision and drainage of abscess - intraoral soft tissue .....	B/R*
D7520	Incision and drainage of abscess - extraoral soft tissue.....	B/R*
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue .....	B/R*
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system .....	B/R*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone .....	B/R*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body .....	B/R*

**Treatment of Fractures-Simple**

D7610	Maxilla - open reduction (teeth immobilized, if present).....	B/R*
D7620	Maxilla - closed reduction (teeth immobilized, if present) .....	B/R*
D7630	Mandible - open reduction (teeth immobilized, if present).....	B/R*
D7640	Mandible - closed reduction (teeth immobilized, if present).....	B/R*
D7650	Malar and/or zygomatic arch - open reduction .....	B/R*
D7660	Malar and/or zygomatic arch - closed reduction. ....	B/R*
D7670	Alveolus - closed reduction, may include stabilization of teeth.....	B/R*
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches .....	B/R*

**Repair of Traumatic Wounds**

D7910	Suture - up to 5cm ( <i>when performed in conjunction with extractions, this service is considered to be included as part of the extraction</i> ) .....	B/R*
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**Complicated Suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)**

D7911	Complicated suture - up to 5 cm .....	B/R*
D7912	Complicated suture - greater than 5 cm.....	B/R*

**Other Repair Procedures**

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	B/R*
D7970	Excision of hyperplastic tissue - per arch.....	B/R*
D7971	Excision of pericoronal gingiva .....	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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### **Orthodontics**

*(Delta Dental's allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). Delta Dental will make an allowance for the cost of a standard orthodontic treatment when specialized orthodontic appliances or procedures are chosen for aesthetic considerations)*

#### **Delta Dental Limited Orthodontic Treatment**

D8010	Limited orthodontic treatment of the primary dentition.....	0.00
D8020	Limited orthodontic treatment of the transitional dentition.....	0.00
D8030	Limited orthodontic treatment of the adolescent dentition.....	0.00
D8040	Limited orthodontic treatment of the adult dentition.....	0.00

#### **Interceptive Orthodontic Treatment**

D8050	Interceptive orthodontic treatment of the primary dentition .....	0.00
D8060	Interceptive orthodontic treatment of the transitional dentition .....	0.00

#### **Comprehensive Orthodontic Treatment**

D8070	Comprehensive orthodontic treatment of the transitional dentition .....	0.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition .....	0.00
D8090	Comprehensive orthodontic treatment of the adult dentition .....	0.00

#### **Minor Treatment to Control Harmful Habits**

D8210	Removable appliance therapy .....	0.00
	<i>(This procedure is an orthodontic service only, and is not equivalent to a night guard, occlusal orthotic device, bite guard or occlusal splint which are provided for non-orthodontic purposes)</i>	
D8220	Fixed appliance therapy .....	0.00

#### **Other Orthodontic Services**

D8660	Pre-orthodontic treatment visit.....	0.00
	<i>(Equivalent to procedure D0150)</i>	
D8670	Periodic orthodontic treatment visit (as part of contract) .....	0.00
	<i>(Delta Dental considers periodic treatment visits to be part of, and included in the contracted fees for, limited, interceptive and comprehensive orthodontic treatment)</i>	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s]) .....	0.00
D8690	Orthodontic treatment (alternative billing to a contract fee) .....	0.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers.....	0.00
D8999	Unspecified orthodontic procedure .....	B/R*

#### **Adjunctive General Services**

D9110	Palliative (emergency) treatment of dental pain - minor procedures .....	50.00
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#### **Anesthesia**

D9220	Deep sedation/general anesthesia - first 30 minutes.....	143.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.....	31.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.....	157.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes .....	29.00

**Professional Consultation** *(Delta Dental considers this procedure to be for a consultation by a specialist whose opinion or advice has been requested regarding a specific problem when routine diagnostic procedures have been performed by a general dentist and the treatment is not provided by the specialist).*

D9310	Consultation - diagnostic service provided by Provider or physician other than requesting Provider or physician .....	54.00
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#### **Miscellaneous Services**

D9930	Treatment of complications (post-surgical) - unusual circumstances .....	B/R*
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\*By Report – Delta Dental will determine the maximum allowance based on a narrative report submitted by the Provider.

**NOTE: The procedures described and allowances indicated on this table are subject to the terms of the Contract and Delta Dental processing policies and may be limited or excluded.**



Note: The above codes and nomenclature are copyright of the American Dental Association. Notes in italic type have been added by Delta Dental for clarification of its processing policies with respect to these procedures and are not part of the ADA's nomenclature.

**Underwritten by:**



**Administered by:**



Delta Dental Insurance Company

**GROUP NAME**



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[www.deltadentalins.com](http://www.deltadentalins.com)

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**Group No:**

**Effective Date:**

**Revised:**

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- [TABLE OF ALLOWANCES]
- NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

## INTRODUCTION

We are pleased to welcome you to the group dental plan for [group name]. Your plan is underwritten by Dentegra Insurance Company and administered by Delta Dental Insurance Company (collectively referred to as "Delta Dental"). Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

### Using This Evidence of Coverage

This Evidence of Coverage booklet discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

**Notice:** *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

### Contact Us

For more information please visit our web site at [www.deltadentalins.com](http://www.deltadentalins.com) or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 800-521-2651 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

*Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809*



Anthony S. Barth, Vice Chairman

## GROUP HIGHLIGHTS

### Plan:

[You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.] [You have a Contract Year plan and deductibles and maximums will be based upon a Contract Year, which is the [12] months starting on the Effective Date and each subsequent 12 month period thereafter.]

### [Benefits:

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Diagnostic and Preventive Benefits:	%	%	%
Basic Benefits:	%	%	%
Major Benefits:	%	%	%
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%
Implant Benefits:	%	%	%
Dental Accident Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

### [Benefits:

We will pay the Maximum Contract Allowance up to the amounts shown on the Table of Allowances, which is attached at the end of this Evidence of Coverage, for Diagnostic & Preventive, Basic, Major, Implant and Dental Accident Benefits. However, Delta Dental will pay a percentage of the Maximum Contract Allowance for the following services:

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

### [Late Entrants:

Benefits for Late Entrants are limited until they have been enrolled in the Contract for [12] consecutive months. Please see the Late Entrants paragraph in the Eligibility and Enrollment section for more information.

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Diagnostic and Preventive Benefits:	%	%	%
Basic Benefits:	%	%	%
Major Benefits:	%	%	%
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%
Implant Benefits:	%	%	%
Dental Accident Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

**[Waiting Periods:**

- [Basic, Major, TMJ, Implant and Dental Accident Benefits are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. [The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the effective date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]
- [Orthodontic Benefits are limited to [dependent children of Primary Enrollees] [Primary Enrollees and their Dependents] who have been enrolled in the Contract for 12 consecutive months. [The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the effective date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]

**Deductible:**

- [ For each Enrollee per [Contract/Calendar] Year is \$XX.]
- [For all family members per [Contract/Calendar] Year is \$XXX.]
- [The lifetime Deductible for each Enrollee is \$XXX.]
- [Orthodontic Benefits are subject to a separate Deductible of \$XXX [per Enrollee/per dependent child enrollee] per [Calendar/Contract Year/lifetime.]
- [TMJ Benefits are subject to a separate Deductible of \$XXX [per Enrollee/per dependent child enrollee] per [Calendar/Contract Year/lifetime.]
- Implant Benefits are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

[The Deductible does not apply to Diagnostic and Preventive Benefits or [Orthodontic/TMJ Benefits].]

[Any Deductible amount you satisfied during the last three (3) months of the year will be applied toward the Deductible for the following year.]

**[Takeover Credit:** Any Deductible you satisfied under the Contractholder's prior plan from January 1st to the Effective Date will be credited toward the Deductible under the Contract.]

**[Takeover Credit:** [ Any Deductible you satisfied for [Orthodontic/TMJ] Benefits under the Contractholder's prior plan from January 1st to the Effective Date will be credited toward the Deductible under the Contract.] [Any lifetime Deductible you satisfied for [Orthodontic/TMJ] Benefits under the Contractholder's prior plan will be credited toward the lifetime Deductible under the Contract.]]

**Maximum:**

- [The maximum payable each [Contract/Calendar] Year for Benefits is \$XXX per Enrollee/Family.]
- [The maximum [lifetime/Calendar Year/Contract Year] amount per [dependent child] Enrollee for Orthodontic Benefits is \$XXX.]
- [A separate maximum amount payable [Contract/Calendar] Year for TMJ Benefits is \$XX per Enrollee.]
- [The lifetime maximum amount per Enrollee for Implant Benefits is \$XXX.]
- [The maximum payable each [Contract/Calendar] Year for Dental Accident Benefits is \$ XXX per Enrollee.]
- [The Maximum Amount does not apply to Diagnostic and Preventive Benefits.]

**[Maximum Takeover Credit:**

We will receive credit for any amounts paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited toward the Calendar Year Maximum.]

***[Lifetime Orthodontic/TMJ Takeover Credit:***

We will receive credit for any amounts paid under the Contractholder's previous dental care contract, if applicable, for [Orthodontic/TMJ Benefits]. These amounts will be credited toward the maximum amounts payable for [Orthodontic/TMJ Benefits.]

[The Maximum Amount does not apply to Diagnostic and Preventive Services.]

**Premiums:**

You are [not] required to contribute towards the cost of your coverage.

You are [not] required to contribute towards the cost of your Dependent's coverage.

We may cancel the Contract [31] days after written notice to the Contractholder if monthly premiums are not paid when due.

**DEFINITIONS**

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network):** the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a PPO Provider. Out-of-Network Benefits are those covered by the Contract but performed by a Premier Provider or a Non-Delta Dental Provider..

**Claim Form:** the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

**Contract:** the written agreement between Delta Dental and the Contractholder under which Benefits are provided.

**Contract Benefit Level:** percentage of Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied.

**Contractholder:** the employer, union or other organization or group contracting to obtain Benefits.

**Deductible:** a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

**Delta Dental** – means collectively, Dentegra Insurance Company and Delta Dental Insurance Company providing and/or administering dental benefit programs. For the purposes of this Contract, Dentegra Insurance Company is the underwriter and Delta Dental Insurance Company is the administrator.

**Delta Dental Premier® Provider (Premier Provider)** – a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under a plan and complies with Delta Dental's administrative guidelines.

**Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee)** – the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating Enrollees.

**Delta Dental PPO<sup>SM</sup> Provider (PPO Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under this PPO dental plan and complies with Delta Dental's administrative guidelines.

**Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee)** -- the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating Enrollees.

**Dependent Enrollee:** an Eligible Dependent enrolled to receive Benefits.

**Effective Date:** the date the program starts. This date is given on this booklet cover.

**Eligible Dependent:** a dependent of an Eligible Employee [or domestic partner ] eligible for Benefits.

**Eligible [Employee/Member ]:** any [employee/member/or retiree ] as eligible for Benefits.

**Enrollee:** an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".

**Enrollee's Effective Date of Coverage:** the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

**[Late Entrant:** an Eligible [Employee/Member] or and/or Eligible Dependent who does not enroll for coverage under the Contract within [31] days of the date first eligible, but later becomes covered; or who requests coverage after previously terminating coverage while still eligible for coverage under the Contract.]

**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [by PPO Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider's in the same geographic area.]
- [by PPO Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim or the Premier Provider's Contracted Fee; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the Program Allowance.]
- [by PPO Providers is the lesser of the Submitted Fee on the claim, the amount shown on the Table of Allowances, or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim, the amount shown on the Table of Allowances, or the Premier Provider's Contracted Fee; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the amount shown on the Table of Allowances.]

**Non-Delta Dental Provider:** a Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines and has not agreed to accept the contracted fees.

**Open Enrollment Period:** the month of the year during which employees may change coverage for the next Contract Year.

**Patient Pays:** Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

**Primary Enrollee:** an Eligible Employee enrolled in the plan to receive Benefits.



**Procedure Code:** the Current Dental Terminology® (CDT) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by us for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualifying Status Change:** a change in:

- legal marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee, spouse or dependent child);
- dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by IRC Section 125.

**Single Procedure:** a dental procedure that is assigned a separate CDT® number.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

**[Table of Allowances:** the list of covered dental services showing the Procedure Code and the maximum amount paid by Delta Dental for each covered Single Procedure. The Table of Allowances is attached at the end of this Evidence of Coverage.]

## **ELIGIBILITY AND ENROLLMENT**

### **Eligibility Requirements**

You will become eligible to receive benefits on the date stated in the Contract after completing any eligibility periods required by the Contractholder as stated in the Contract.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Lawful spouse [or domestic partner named in the Contractholder's Affidavit of Domestic Partnership];
- Unmarried dependent children from birth to [the end of the month of] their 19th birthday or 25th birthday, if a full-time student in an accredited school. Proof of full-time student status must be given to Delta Dental within 60 days when requested. "Children" includes natural children, step-children, adopted children, [children of your domestic partner,] foster children and children for which the employee has been appointed legal guardian. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. [However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any [Contract/Calendar] Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the [Contract/Calendar] Year immediately following said child's fourth birthday.]
- An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is mostly dependent on the Primary Enrollee for support and maintenance. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

### **Enrollment Requirements**

[If the Contractholder is paying all premiums for you [and your dependents, everyone is] [, you are] automatically enrolled.]

[If you are paying all or a portion of premiums for yourself or your dependents then:]

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees [who are not covered under another group dental plan] for coverage.
- [You must pay Premiums in the manner elected by the Contractholder and approved by us. If coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, you may not re-enroll except during an Open Enrollment Period.]  
[You must pay Premiums in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.]
- [If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. If coverage is dropped other than during an Open Enrollment Period, your dependents may not be re-enrolled at any time, unless there is a court order requiring dependent coverage.]  
[If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]  
[If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us. Dependent Enrollees must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. However, the eligibility date for young children, under the age of four (4), may be delayed until the beginning of any [[Contract/Calendar] Year including the [Contract/Calendar] Year immediately following the child's fourth birthday. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]
- [If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]  
[If both you and your spouse are eligible persons, one of you may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[If both you and your spouse are eligible persons, one of you may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

### **[Late Entrant]**

[You and/or your dependents will be considered a Late Entrant if:

- You and/or your Eligible Dependents do not enroll for coverage under the Contract within [31] days of the date first eligible, but later become covered; or
- You request coverage for yourself and/or your Eligible Dependents after previously terminating coverage while you remained eligible for coverage under the Contract.

Benefits for Late Entrants are reduced as shown in the Group Highlights section at the beginning of this booklet.]

**[Flexible Dual Choice**

The Flexible Dual Choice product consists of this Delta Dental PPO (PPO) fee-for-service plan and Delta Dental's prepaid dental plan (DeltaCare<sup>®</sup> USA). The Primary Enrollee and his/her covered dependents may move from this PPO plan to the DeltaCare USA plan or from the DeltaCare USA plan to this PPO plan on a monthly basis. The Primary Enrollee and his/her covered dependents will only be covered under one plan at a time. To make this change, the Primary Enrollee must notify Flexible Dual Choice's Customer Service department at (866) 225-1112 by the 15<sup>th</sup> of the month. The dental plan change will be effective the first day of the following month. The Benefits, Limitations and Exclusions listed in this booklet apply when the Enrollee is covered under the PPO plan.]

Treatment in progress must be completed under the plan in which treatment is started. No plan changes may be made while the Primary Enrollee and his/her covered dependents are undergoing dental treatment.

**[Loss of Eligibility**

Your coverage ends on the [last day of the month][day] you [stop working for the Contractholder /are no longer an Eligible Member of the Contractholder, stop paying the required premiums for coverage] or immediately when this program ends. Your dependents lose coverage when your coverage ends or on the date when dependent status is lost.

**Continuation of Benefits**

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within [31] days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

**[Strike, Lay-off and Leave of Absence]**

You and your dependents will not be covered for any dental services received while you are on strike, lay-off, leave of absence, other than [an approved leave of absence or] as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law\*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same [Contract/Calendar] Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different [Contract/Calendar] Year, new Deductibles and maximums will apply.

Coverage will resume [the first day of the month after] [the date] you return to work, provided you submit an enrollment card requesting that coverage be reactivated.

\*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

**Important:** The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same [Contract/Calendar] Year, Deductibles and maximums will resume as if you were never gone.]

**[Continued Coverage under USERRA]**

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.]

**[Continuation of Coverage Under COBRA]**

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).]

**BENEFITS, LIMITATIONS AND EXCLUSIONS**

We will pay the Benefits for the types of dental services as described below. We will pay Benefits only for covered services. The services provided through the Contract are described in the Group Highlights section at the beginning of this booklet. The Contract covers several categories of benefits when a Provider provides the services and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, for specific services are listed in the Group Highlights section. If you receive dental services from a Provider outside the state of XXXXX, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

**Enrollee Coinsurance**

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown [in the Group Highlights section/below], subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for

covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

### **Deductible**

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in the Group Highlights section. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

### **Maximum Amount**

Most dental programs have a Maximum Amount. This is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in the Group Highlights section. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

### **Benefits**

To help you understand the types of procedures that are included in each category, the following is a description of each of the categories of services that are covered under the Contract.

[We will pay the Contract Benefit Level of Maximum Contract Allowance shown [in the Group Highlights section/below] for the following services:]

#### **Diagnostic and Preventive Benefits:**

- Diagnostic: procedures to assist the Provider in choosing required dental treatment.
- Preventive: cleaning, topical application of fluoride solutions and space maintainers. Note that periodontal cleaning in the presence of gingival inflammation is considered to be periodontal and is covered as a [Basic Benefit.
- [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]

#### **Basic Benefits:**

- [Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).]
- General Anesthesia or IV Sedation: when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
- [Endodontics: treatment of diseases and injuries of the tooth pulp.]
- [Periodontics: treatment of gums and bones supporting teeth.]
- Palliative: emergency treatment to relieve pain.
- [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]
- [Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
- [Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.]

**Major Benefits:**

- [Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).]
- [Endodontics: treatment of diseases and injuries of the tooth pulp.]
- [Periodontics: treatment of gums and bones supporting teeth.]
- [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.]
- [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.]

**[Orthodontic Benefits:]**

Procedures performed by a Provider, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.]

**[Temporomandibular Joint Dysfunction (TMJ) Benefits:**

Intra-oral services provided by a licensed Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofascial pain dysfunction or malfunction of the temporomandibular (jaw) joint.]

**[Implant Benefits:**

Procedures performed by a Provider for: endodontic, endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis.]

**[Dental Accident Benefits:**

An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and stayplate.]

**Note on additional benefits during pregnancy** - When an Enrollee is pregnant, we will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each [12 month period, Calendar Year, Contract Year] while the Enrollee is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

**Limitations and Exclusions**

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes Limitations and Exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. Please read the following sections to help you understand the limitations and exclusions of this dental plan.

**Limitations**

Benefits to Enrollees are limited as follows:

***Limitations on Diagnostic and Preventive Benefits:***

- We will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) and topical application of fluoride solutions no more than [twice in any 12 month] period. [Note that periodontal cleanings are covered as a [Basic Benefit] and routine

cleanings are covered as a Diagnostic and Preventive Benefit.] See note on additional benefits during pregnancy.

- Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- X-ray limitations:
  - (1) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Provider's Accepted Fee for a complete intraoral series.
  - (2) When a panoramic film is submitted with supplemental film(s), we will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series
  - (3) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.
  - (4) A complete intraoral series and panoramic film by the same Provider/Provider office are each limited to once every [five (5)] years.
  - (5) Bitewing x-rays are limited to [two (2) times in any 12 month period] when provided to Enrollees under age 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries.
- [Topical application of fluoride solutions is limited to Enrollees to age 19].
- Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14]. For Enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridge or removable partial denture can be placed.
- Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when Orthodontic services are a covered Benefit.
- [Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.]

**Limitations on Basic Benefits:**

- [Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.]
- We will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months] of treatment if the service is provided by the same Provider/Provider office.
- We limit payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, we may allow stainless steel crowns on permanent teeth as a [Major Benefit.]
- [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider/Provider office.]
- [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing. See note on additional benefits during pregnancy.]

***Limitations on Major Benefits:***

- Crowns and inlays/onlays are covered no more often than once in any [five (5) year period] except when we determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Prosthodontic appliances [and/or implants] that were provided under any Delta Dental program will be replaced only after [five (5) years] have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. [Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. We will not pay for bone grafts provided with implants on the same day of service. Our payment for implant removal is limited to one (1) for each implant during your lifetime whether provided under a Delta Dental program or any other dental care plan.]
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- [The initial installation of a prosthodontic appliance [and/or implants] is not a Benefit unless the prosthodontic appliance [and/or implant, bridge] or denture is made necessary by natural, permanent teeth extraction occurring during a time you were eligible [under a Delta Dental program / or Contractholder's prior plan.]
- We limit payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement.
  - (1) Denture rebase is limited to one (1) per arch in a 24 month period.
  - (2) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- [We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture.]

***[Limitations on Orthodontic Benefits:]***

- The maximum amount payable for each Enrollee during the [Enrollee's lifetime/Calendar Year/Contract Year] is shown in the Group Highlights section.
- [Orthodontic Benefits will be provided in two (2) payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months or less, one (1) payment will be made.]
- Benefits are not paid to repair or replace any orthodontic appliance received under this program.
- Benefits are not provided for orthodontic retreatment procedures.
- Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the Orthodontic Contract Benefit Level and maximum if covered as Benefits under our standard processing policies..
- [Orthodontic Benefits are limited to dependent child Enrollees under the age of 19 or [25 if full-time student]].

***[Limitations on TMJ Benefits:***

- TMJ Benefits are subject to all the Limitations, Exclusions and other terms of this dental care program.



- We will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health program which provides TMJ Benefits.
- Benefits are limited to those intra-oral services which would normally be provided by a licensed Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
- Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this program are excluded.
- Any procedure paid under any other category of Benefits by this program is not covered as a TMJ Benefit.]

**[Limitations on Implant Benefits:**

- Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in the Contract. Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
- We will not pay to replace any implant that you received in the previous five (5) years.
- We will not pay for bone graphs provided with implants on the same day of service.
- We will pay for implant removal only when the Enrollee's coverage includes Implant Benefits and is limited to one (1) for each implant during your lifetime whether provided under us or any other dental care plan.
- Prosthodontic devices and procedures associated with, but not included within the definition of "Implants" are not subject to the Implant Maximum.]

**[Limitations on Dental Accident Benefits:**

- The dental accident must occur while you are covered under the Contract.
- Services and procedures must be provided within 180 days following the dental accident and while you are covered under the Contract.]

**Limitations on All Benefits - Optional Services:** Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- [a composite restoration instead of an amalgam restoration on posterior teeth;]
- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
- an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

**Exclusions**

The Contract covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your Provider.

We do not pay benefits for:

- treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.

- maxillofacial prosthetics.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects, illness, injury or birth abnormalities.
- treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- any Single Procedure started prior to the date you became eligible for services under this plan.
- prescribed drugs, medication, pain killers, antimicrobial agents or experimental procedures.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- fixed bridges and removable partials for Enrollees under age 16.
- interim implants.
- resin-based inlays and onlays.
- overdentures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- services or supplies covered by any other health plan of the Contractholder.
- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [the initial placement of any prosthodontic appliance [or implants], unless such placement is needed to replace one or more natural, permanent teeth extracted while you are covered under the Contract or was covered under [any dental care program with us / the Contractholder's prior dental plan]. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.]
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefit section, if applicable.
- procedures performed for the purpose of orthodontic treatment except as provided under the Orthodontic Benefit section, if applicable.
- services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ) except as provided under the TMJ Benefit section, if applicable.

- [services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures except as provided under the Implant Benefit section, if applicable.]
- [services not included on the Table of Allowances.]
- [services or supplies for oral surgery, general anesthesia or IV sedation, palliative treatment, or sealants.]
- [services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).]
- [services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
- [services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).]
- [services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations).]
- [services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges)].

## **PRE-TREATMENT ESTIMATES**

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any deductibles, so please remember to figure in your deductible if necessary.

## **COORDINATION OF BENEFITS**

[We coordinate the Benefits under the Contract with your Benefits under any other group or prepaid program or Benefit plan including another Delta Dental. (This does not apply to a blanket school accident policy.) Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Provider's fees for the covered services.]

[We coordinate the Benefits under the Contract with your Benefits under any other group or prepaid program or insurance policy designed to fully integrate with other policies. Benefits under this program may be reduced so that combined coverage does not exceed the Maximum Contract Allowance.]

If this is the "primary" program, we will not reduce Benefits, but if the other program is the primary one, we will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- How do we determine which Plan is the “primary” program?
  - (1) If the other Plan is not primarily a dental plan, this Plan is primary, except the Enrollee’s medical plan, if any, will be primary for oral surgery procedures covered under such plan.
  - (2) If the other Plan is a dental program, the following rules are applied:
    - a) the Plan covering you as an employee is primary over a Plan covering you as a dependent.
    - b) the Plan covering you as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      - i) secondary to the Plan covering the insured person as a dependent and
      - ii) primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
  - (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
    - c) However, if the other Plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
    - d) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent’s spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).
  - (4) The benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
  - (5) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following will be the order of benefit determination:
    - a) First, the benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person’s dependent);
    - b) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

- (6) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the Plan which covered you for the shorter term.

## SELECTING YOUR PROVIDER

### Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a PPO Provider, Premier or a Non-Delta Dental Provider. In addition, you and your family members can see different Providers.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a PPO Provider.** To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

### Locating a Delta Dental PPO Provider

There are two ways in which you can locate a PPO Provider near you:

- You may access information through our web site at [www.deltadentalins.com](http://www.deltadentalins.com). This web site includes a Provider search function allowing you to locate PPO Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 800-521-2651 and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## HOW CLAIMS ARE PAID

### Payment for Services — PPO Provider

Payment for covered services performed for you by a PPO Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim, [the amount shown on the Table of Allowances] or the PPO Provider's Contracted Fee. PPO Providers have agreed to accept the PPO Provider's Contracted Fee as the full charge for covered services. PPO Providers have contractually agreed to charge no more than the PPO Provider's Contracted Fee even for services that are not covered under the Contract provided the service(s) are included in their agreement with us.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Group Highlights section. Delta Dental's Payment is sent directly to the PPO Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

### Payment for Services — Premier Provider

Payment for covered services performed for you by a Premier Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim, [the amount shown on the Table of Allowances] or the PPO Provider's Contracted Fee for a [PPO Provider in the same geographic area/Program Allowance]. Premier Providers have agreed to accept the Premier Provider's Contracted Fee as the full charge for covered services. Premier Providers have contractually agreed to charge no more than Premier Provider's Contracted Fee even for services that are not covered under the Contract provided the service(s) are included in their agreement with us.

## Payment for Services — Non-Delta Dental Provider

Payment for services performed for you by a Non-Delta Dental Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Group Highlights section. Non-Delta Dental Providers have no agreement with Delta Dental and are free to balance bill you for any difference between what Delta pays and the Submitted Fee.

When dental services are received from a Non-Delta Dental Provider, Delta Dental's Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Delta Dental Provider's actual charges, your out-of-pocket cost may be significantly higher.

## How to Submit a Claim

Delta Dental does not require special claim forms. However, most dental offices do have Claim Forms available. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

*Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809*

## Payment Guidelines

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO or Premier Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO or Premier Provider that you were an Enrollee of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all PPO Providers and Premier Providers how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any services are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact us.

## COMPLAINTS AND APPEALS

Our commitment to you is to ensure quality throughout the entire dental benefit process: from the courtesy extended to you by our Customer Service Representatives to the dental services provided by PPO and Premier Providers. If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our web site at [www.deltadentalins.com](http://www.deltadentalins.com)

Complaints or Appeals regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 800-521-2651.

When you write, please include the name of the Enrollee, the Primary Enrollee's name and ID number, and your telephone number on all correspondence. You should also include a copy of the claim form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any complaint, or appeal process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to us giving reasons why you believe the denial was wrong. You may also ask us to examine any additional information you include that may support your complaint, or appeal.

Send your complaint, or appeal to us at the address shown below:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809

We will send you a written acknowledgment within 5 days upon receipt of your complaint or appeal. We will make a full and fair review within 30 days after we receive the complaint or appeal. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If you believe you need further review of your complaint or appeal you may [file a request with us for a second level review or] contact your state insurance regulatory agency.

## **PROVISIONS REQUIRED BY LAW**

### **Clinical Examination**

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us, in or near your community or residence. We will in every case hold such information and records confidential.

### **Notice of Claim Form**

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may download a Claim Form from our web site.

### **Written Notice of Claim/Proof of Loss**

We must be given written proof of loss within [12 months] after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason,

provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within [12 months] of the termination of the Contract.

**Time of Payment**

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

**To Whom Benefits Are Paid**

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

**Misstatements on Application; Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at enrollment.

**Legal Actions**

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.



**Dentegra Company  
TABLE OF ALLOWANCES**

<b>PROCEDURE NUMBER</b>	<b>PROCEDURE DESCRIPTION</b>	<b>TABLE OF ALLOWANCE</b>
<b><u>Clinical Oral Evaluations</u></b>		
D0120	Periodic oral evaluation - established patient.....	26.00
D0140	Limited oral evaluation - problem focused.....	42.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	26.00
D0150	Comprehensive oral evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
D0160	Detailed and extensive oral evaluation - problem focused, by report <i>(limited to one per Provider all subsequent ones will be benefited as D0120)</i> .....	56.00
D0180	Comprehensive periodontal evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
<b><u>Radiographs/Diagnostic Imaging</u></b> (Including Interpretation) <i>(Any combination of bitewings, periapicals and panoramic films taken on the same day will be combined as a complete series when the fees are equal to or exceed that of a complete series)</i>		
D0210	Intraoral - complete series (including bitewings) .....	78.00
D0220	Intraoral - periapical - first film .....	16.00
D0230	Intraoral - periapical - each additional film.....	12.00
D0240	Intraoral occlusal film.....	19.00
D0250	Extraoral - first film.....	19.00
D0260	Extraoral - each additional film .....	14.00
D0272	Bitewings - two films .....	25.00
D0273	Bitewings - three films .....	34.00
D0274	Bitewings - four films.....	43.00
D0277	Vertical bitewings - seven to eight films.....	53.00
D0330	Panoramic film .....	70.00
D0340	Cephalometric film <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	70.00
D0350	Oral/facial photographic images <i>(This is a benefit only once per case in conjunction with orthodontic services)</i> .....	42.00
<b><u>Test and Examinations</u></b>		
D0470	Diagnostic casts <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	54.00
<b><u>Dental Prophylaxis</u></b>		
D1110	Prophylaxis - adult .....	54.00
D1120	Prophylaxis - child (to age 14).....	43.00
<b><u>Topical Fluoride - (Office Procedure)</u></b>		
D1203	Topical Application of fluoride - child (through age 13).....	22.00
D1204	Topical Application of fluoride - adult <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
D1206	Topical fluoride varnish; therapeutic Application for moderate to high caries risk patients <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
<b><u>Other Preventive Services</u></b>		
D1351	Sealant - per tooth .....	28.00
	<i>(benefit to permanent first molars through age 8 and second molars through age 15)</i>	
<b><u>Space Maintainers (Passive Appliances)</u></b>		
D1510	Space maintainers – fixed, unilateral.....	202.00
D1515	Space maintainers – fixed, bilateral.....	310.00
D1520	Space maintainers – removable, unilateral .....	256.00
D1525	Space maintainers – removable, bilateral .....	287.00
D1555	Removal of fixed space maintainer .....	50.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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**Amalgam Restorations (Including Polishing)** *(the fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp cap, local anesthesia, polishing, occlusal adjustment, caries, removal and gingivectomy on the same date of service. Replacement of restorations by the same Provider is a benefit after 24 months)*

D2140	Amalgam - one surface, primary or permanent.....	59.00
D2150	Amalgam - two surfaces, primary or permanent .....	78.00
D2160	Amalgam - three surfaces, primary or permanent.....	93.00
D2161	Amalgam - four or more surfaces, primary or permanent .....	109.00

**Resin-Based Composite Restorations-Direct**

D2330	Resin-based composite - one surface, anterior.....	71.00
D2331	Resin-based composite - two surface, anterior .....	87.00
D2332	Resin-based composite - three surfaces, anterior.....	109.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior). ....	135.00
D2391	Resin-based composite - one surface, posterior .....	59.00
D2392	Resin-based composite - two surfaces, posterior .....	78.00
D2393	Resin-based composite - three surfaces, posterior .....	93.00
D2394	Resin-based composite - four or more surfaces, posterior .....	171.00

*Fees for Cast Restorations should include tooth preparation, pulp capping, laboratory costs, temporary restorations, porcelain margins, cement bases, routine buildup/substructure, impressions, local anesthesia, occlusal correction, preparation of the gingival tissue and any recementation or repair within six months.*

**Inlay/Onlay Restorations**

D2510	Inlay - metallic - one surface.....	233.00
D2520	Inlay - metallic - two surfaces .....	271.00
D2530	Inlay - metallic - three or more surfaces .....	305.00
D2542	Onlay - metallic - two surfaces .....	353.00
D2543	Onlay - metallic - three surfaces.....	377.00
D2544	Onlay - metallic - four or more surfaces .....	394.00
D2610	Inlay - porcelain/ceramic - one surface.....	233.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	271.00
D2630	Inlay - porcelain/ceramic - three or more surfaces .....	305.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	353.00
D2643	Onlay - porcelain/ceramic - three surfaces.....	377.00
D2644	Onlay - porcelain/ceramic - four or more surfaces .....	394.00

**Crowns-Single Restorations Only**

D2740	Crown - porcelain/ceramic substrate .....	375.00
D2750	Crown - porcelain fused to high noble metal .....	383.00
D2751	Crown - porcelain fused to predominantly base metal .....	341.00
D2752	Crown - porcelain fused to noble metal.....	357.00
D2780	Crown - cast 3/4 high noble metal .....	395.00
D2781	Crown - cast 3/4 predominantly base metal .....	372.00
D2782	Crown - cast 3/4 noble metal.....	386.00
D2783	Crown - cast 3/4 porcelain/ceramic .....	405.00
D2790	Crown - full cast high noble metal .....	372.00
D2791	Crown - full cast predominantly base metal .....	330.00
D2792	Crown - full cast noble metal .....	349.00
D2794	Crown - titanium.....	372.00

**Other Restorative Services**

D2910	Recement inlay, onlay, or partial coverage restoration .....	28.00
D2915	Recement cast or prefabricated post and core .....	28.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D2920	Recement crown.....	28.00
D2930	Prefabricated stainless steel crown - primary tooth.....	136.00
D2931	Prefabricated stainless steel crown - permanent tooth .....	98.00
D2932	Prefabricated resin crown .....	98.00
D2933	Prefabricated stainless steel crown with resin window.....	B/R*
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth .....	B/R*
D2940	Sedative Filling .....	50.00
D2950	Core build-up, including any pins ( <i>considered part of crown fee except in exceptional circumstances or for endodontically treated teeth</i> ).....	78.00
D2951	Pin retention - per tooth, in addition to restoration .....	28.00
D2952	Post and core in addition to crown, indirectly fabricated .....	116.00
D2954	Prefabricated post and core in addition to crown .....	98.00
D2960	Labial veneer (resin laminate) - chairside .....	147.00
D2961	Labial veneer (resin laminate) - laboratory .....	233.00
D2962	Labial veneer (porcelain laminate) - laboratory .....	299.00
D2971	Additional procedures to construct new crown under existing partial denture framework .....	B/R*
D2980	Crown repair .....	B/R*

#### **Pulpotomy**

D3220	Therapeutic pulpotomy (excluding final restoration).....	81.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.....	81.00

#### **Endodontic Therapy** (Including treatment plan, clinical procedures and follow-up care)

D3310	Endodontic therapy, anterior tooth (excluding final restoration).....	350.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration).....	415.00
D3330	Endodontic therapy, molar (excluding final restoration) .....	527.00

#### **Endodontic Retreatment**

*Retreatment of root canal therapy within 24 months of the initial procedure is included in the original contracted fee when performed by the same Provider or in the original submitted fee when performed by an out-of-network Provider.*

D3346	Retreatment of previous root canal therapy - anterior.....	419.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	496.00
D3348	Retreatment of previous root canal therapy - molar .....	605.00

#### **Apexification/Recalcification Procedures**

D3351	Apexification/recalcification - initial visit.....	225.00
D3352	Apexification/recalcification - interim medication replacement.....	98.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy).....	332.00

#### **Apicoectomy/Periradicular Services**

D3410	Apicoectomy/periradicular surgery - anterior .....	273.00
D3421	Apicoectomy/periradicular surgery - bicuspid - (first root) .....	341.00
D3425	Apicoectomy/periradicular surgery - molar - (first root) .....	400.00
D3426	Apicoectomy/periradicular surgery - (each additional root).....	124.00
D3430	Retrograde filling - per root.....	81.00
D3450	Root amputation - per root.....	186.00

#### **Other Endodontic Procedures**

D3920	Hemisection (including any root removal), not including root canal therapy .....	186.00
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#### **Surgical Services (Including usual postoperative care)**

*On periodontal surgical procedures, the surgery is considered to include any surgical re-entry or scaling and root planing for three years.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant...	245.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	87.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .....	310.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	186.00
D4249	Clinical crown lengthening - hard tissue .....	B/R*
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .....	451.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant .....	270.00
D4270	Pedicle soft tissue graft procedure ( <i>limited to two sites per quadrant</i> ).....	341.00
D4271	Free soft tissue graft procedure (including donor site surgery) ( <i>limited to two sites per quadrant</i> ) .....	391.00
<b><u>Non-Surgical Periodontal Service</u></b>		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	124.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant .....	74.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis .....	54.00
<b><u>Other Periodontal Services</u></b>		
D4910	Periodontal maintenance procedure.....	68.00
<b><u>Complete Dentures</u></b> ( <i>Includes routine post delivery care and relining for the first six months after placement</i> )		
D5110	Complete denture - maxillary.....	426.00
D5120	Complete denture - mandibular .....	426.00
D5130	Immediate denture - maxillary .....	465.00
D5140	Immediate denture - mandibular.....	465.00
<b><u>Partial Dentures</u></b> ( <i>Includes routine post delivery care for the first six months after placement</i> )		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) .....	295.00
D5212	Mandibular partial denture -resin base (including any conventional clasps, rests and teeth).....	295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	378.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	378.00
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) .....	310.00
<b><u>Adjustment to Dentures</u></b>		
D5410	Adjust complete denture - maxillary .....	37.00
D5411	Adjust complete denture - mandibular.....	37.00
D5421	Adjust partial denture - maxillary .....	37.00
D5422	Adjust partial denture - mandibular.....	37.00
<b><u>Repairs to Complete Dentures</u></b>		
D5510	Repair broken complete denture base .....	81.00
D5520	Replace missing broken tooth - complete denture (each tooth).....	74.00
<b><u>Repairs to Partial Dentures</u></b>		
D5610	Repair resin denture base .....	81.00
D5620	Repair cast framework.....	115.00
D5630	Repair or replace broken clasp.....	109.00
D5640	Replace broken teeth - per tooth .....	74.00
D5650	Add tooth to existing partial denture .....	96.00
D5660	Add clasp to existing partial denture.....	109.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Denture Rebase Procedures</u></b> (Any rebase includes relining and any adjustments for six months following placement. One rebase per arch is covered in a 24 month period)		
D5710	Rebase complete maxillary denture .....	248.00
D5711	Rebase complete mandibular denture.....	248.00
D5720	Rebase maxillary partial denture .....	223.00
D5721	Rebase mandibular partial denture .....	223.00
<b><u>Denture Reline Procedures</u></b>		
D5730	Reline complete maxillary denture (chairside) .....	144.00
D5731	Reline complete mandibular denture (chairside).....	144.00
D5740	Reline maxillary partial denture (chairside) .....	136.00
D5741	Reline mandibular partial denture (chairside).....	136.00
D5750	Reline complete maxillary denture (laboratory) .....	217.00
D5751	Reline complete mandibular denture (laboratory) .....	217.00
D5760	Reline maxillary partial denture (laboratory).....	205.00
D5761	Reline mandibular partial denture (laboratory) .....	205.00
<b><u>Interim Prosthesis</u></b>		
D5820	Interim partial denture - maxillary .....	175.00
D5821	Interim partial denture - mandibular.....	175.00
<b><u>Other Removable Prosthetic Services</u></b>		
D5850	Tissue conditioning - maxillary .....	47.00
D5851	Tissue conditioning - mandibular .....	47.00
<b><u>Maxillofacial Prosthetics</u></b>		
D5900-5999 Maxillofacial prosthetic procedures are generally not benefits of Delta Dental programs. When covered, they follow the benefits required under state regulatory guidelines, and typically are limited to services provided to newborn, dependent children for medically diagnosed congenital defects, birth abnormalities.		
<b><u>Implant Services</u></b>		
<b><u>Pre-Surgical Services</u></b>		
D6190	Radiographic/surgical implant index.....	B/R*
<b><u>Surgical Services</u></b>		
D6010	Surgical placement of implant body: endosteal implant .....	0.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant..... (Delta Dental considers this procedure part of the transitional prosthesis which is not a covered benefit)	0.00
D6040	Surgical placement: eposteal implant.....	0.00
D6050	Surgical placement: transosteal implant.....	0.00
<b><u>Implant Supported Prosthetics</u></b>		
<b><u>Supporting Structures</u></b>		
D6055	Dental implant supported connecting bar .....	0.00
D5212	Mandibular abutment — includes placement .....	0.00
D6056	Prefabricated abutment – includes placement .....	0.00
D6057	Custom abutment — includes placement.....	0.00
<b><u>Implant/Abutment Supported Removable Dentures</u></b>		
D6053	Implant/abutment supported removable denture for completely edentulous arch .....	0.00
D6054	Implant/abutment supported removable denture for partially edentulous arch .....	0.00
<b><u>Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)</u></b>		
D6078	Implant/abutment supported fixed denture for completely edentulous arch.....	0.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch .....	0.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Single Crowns, Abutment Supported</u></b>		
D6058	Abutment supported porcelain/ceramic crown .....	0.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	0.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	0.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	0.00
D6062	Abutment supported cast metal crown (high noble metal) .....	0.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	0.00
D6064	Abutment supported cast metal crown (noble metal) .....	0.00
D6094	Abutment supported crown — (titanium) .....	0.00
<b><u>Single Crowns, Implant Supported</u></b>		
D6065	Implant supported porcelain/ceramic crown .....	0.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) .....	0.00
D6067	Implant supported metal crown (titanium, titanium alloy, noble metal) .....	0.00
<b><u>Fixed Partial Denture, Abutment Supported</u></b>		
D6068	Abutment supported retainer for porcelain/ceramic FPD .....	0.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	0.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) .....	0.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	0.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal) .....	0.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal) .....	0.00
D6074	Abutment supported retainer for cast metal FPD (noble metal) .....	0.00
D6194	Abutment supported retainer crown for FPD — (titanium) .....	0.00
<b><u>Fixed Partial Denture, Implant Supported</u></b>		
D6075	Implant supported retainer for ceramic FPD .....	0.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) .....	0.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) .....	0.00
<b><u>Other Implant Services</u></b>		
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis .....	0.00
D6090	Repair implant supported prosthesis .....	B/R*
D6095	Repair implant abutment .....	B/R*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment .....	0.00
	<i>(D6091 is a benefit only after the prosthodontic time limitation (usually 5 years) has elapsed since the implant attachment was placed)</i>	
D6092	Recent implant/abutment supported crown .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6093	Recent implant/abutment supported fixed partial denture .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6094	CDT coding places procedure D6094 immediately following D6064 .....	0.00
D6190	CDT coding places procedure D6190 immediately before D6010 .....	0.00
D6194	CDT coding places procedure D6194 immediately following D6074 .....	0.00
D6199	Unspecified implant procedure .....	B/R*
<b><u>Fixed Partial Denture Pontics</u></b>		
D6205	Pontic - indirect resin based composite .....	332.00
D6210	Pontic - cast high noble metal .....	370.00
D6211	Pontic - cast predominantly base metal .....	332.00
D6212	Pontic - cast noble metal .....	357.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D6214	Pontic - titanium .....	370.00
D6240	Pontic - porcelain fused to high noble metal .....	369.00
D6241	Pontic - porcelain fused to predominantly base metal.....	346.00
D6242	Pontic - porcelain fused to noble metal .....	353.00
<b><u>Fixed Partial Denture Retainers—Inlays/Onlays</u></b>		
D6545	Retainer - cast metal for resin bonded fixed prosthesis .....	155.00
D6600	Inlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6602 will be given</i> ) .....	260.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6603 will be given</i> ) .....	302.00
D6602	Inlay - cast high noble metal, two surfaces .....	260.00
D6603	Inlay - cast high noble metal, three or more surfaces .....	302.00
D6604	Inlay - cast predominately base metal, two surfaces.....	260.00
D6605	Inlay - cast predominately base metal, three or more surfaces .....	302.00
D6606	Inlay - cast noble metal, two surfaces .....	260.00
D6607	Inlay - cast noble metal, three or more surfaces .....	302.00
D6608	Onlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6610 will be given</i> ).....	361.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6611 will be given</i> ).....	388.00
D6610	Onlay - cast high noble metal, two surfaces.....	361.00
D6611	Onlay - cast high noble metal, three or more surfaces.....	388.00
D6612	Onlay - cast predominately base metal, two surfaces.....	361.00
D6613	Onlay - cast predominately base metal, three or more surfaces.....	388.00
D6614	Onlay - cast noble metal, two surfaces.....	361.00
D6615	Onlay - porcelain/ceramic, three or more surfaces .....	388.00
D6624	Inlay - titanium .....	302.00
D6634	Onlay - titanium.....	388.00
<b><u>Fixed Partial Denture Retainers—Crowns</u></b>		
D6710	Crown - indirect resin based composite .....	B/R*
D6750	Crown - porcelain fused to high noble metal .....	383.00
D6751	Crown - porcelain fused to predominantly base metal .....	341.00
D6752	Crown - porcelain fused to noble metal.....	357.00
D6780	Crown - 3/4 cast high noble metal .....	395.00
D6781	Crown - 3/4 cast predominantly base metal .....	372.00
D6782	Crown - 3/4 cast noble metal.....	386.00
D6783	Crown - 3/4 cast porcelain/ceramic ( <i>an alternate benefit of D6780 will be given</i> ) .....	405.00
D6790	Crown - full cast high noble metal .....	372.00
D6791	Crown - full cast predominantly base metal .....	330.00
D6792	Crown - full cast noble metal .....	349.00
D6794	Crown - titanium.....	378.00
<b><u>Other Fixed Partial Denture Services</u></b>		
D6930	Recement fixed partial denture.....	39.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.....	124.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.....	98.00
D6973	Core buildup for retainer, including any pins .....	96.00
D6980	Fixed partial denture repair.....	B/R*
<b><u>Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7140	Extraction, erupted tooth or exposed root (elevation &/or forceps removal) .....	62.00
<b><u>Surgical Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7210	Surgical removal of erupted tooth.....	118.00
D7220	Removal of impacted tooth - soft tissue .....	155.00
D7230	Removal of impacted tooth - partially bony .....	205.00
D7240	Removal of impacted tooth - completely bony .....	242.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D7250	Surgical removal of residual tooth roots (cutting procedure).....	118.00
<b><u>Other Surgical Procedures</u></b>		
D7280	Surgical access of an unerupted tooth .....	155.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	B/R*
D7285	Biopsy of oral tissue - hard (bone, teeth) .....	158.00
D7286	Biopsy of oral tissue - soft .....	118.00
D7290	Surgical repositioning of teeth .....	B/R*
<b><u>Alveoloplasty – Surgical Preparation of Ridge</u></b>		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	121.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	73.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ( <i>usually in preparation for prosthesis</i> ).....	167.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	101.00
<b><u>Vestibuloplasty</u></b>		
D7340	Vestibuloplasty - ridge extension - (secondary epithelialization).....	161.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachments and management of hypertrophied and hyper plastic tissue) .....	326.00
<b><u>Surgical Excision of Soft Tissue Lesions</u></b>		
D7410	Excision of benign lesion to 1.25 cm .....	B/R*
D7411	Excision of benign lesion diameter greater than 1.25 cm .....	B/R*
D7412	Excision of benign lesion complicated.....	B/R*
D7413	Excision of malignant lesion, up to 1.25 cm .....	B/R*
D7414	Excision of malignant lesion greater than 1.25.....	B/R*
D7415	Excision of malignant lesion, complicated.....	B/R*
<b><u>Surgical Excision of Intra-Osseous Lesions</u></b>		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.....	B/R*
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7460	Removal of benign nonodontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7461	Removal of benign nonodontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7465	Destruction of lesion(s) by physical or chemical methods.....	B/R*
<b><u>Excision of Bone Tissue</u></b>		
D7471	Removal of lateral exostosis (maxilla or mandible) .....	524.00
D7472	Removal of torus palatinus .....	524.00
D7473	Removal of torus mandibularis.....	524.00
<b><u>Surgical Incision</u></b>		
D7510	Incision and drainage of abscess - intraoral soft tissue.....	B/R*
D7520	Incision and drainage of abscess - extraoral soft tissue.....	B/R*
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue .....	B/R*
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system.....	B/R*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.....	B/R*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.....	B/R*
<b><u>Treatment of Fractures-Simple</u></b>		
D7610	Maxilla - open reduction (teeth immobilized, if present) .....	B/R*
D7620	Maxilla - closed reduction (teeth immobilized, if present).....	B/R*
D7630	Mandible - open reduction (teeth immobilized, if present).....	B/R*



PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D7640	Mandible - closed reduction (teeth immobilized, if present) .....	B/R*
D7650	Malar and/or zygomatic arch - open reduction .....	B/R*
D7660	Malar and/or zygomatic arch - closed reduction.....	B/R*
D7670	Alveolus - closed reduction, may include stabilization of teeth .....	B/R*
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches .....	B/R*
<b><u>Repair of Traumatic Wounds</u></b>		
D7910	Suture - up to 5cm ( <i>when performed in conjunction with extractions, this service is considered to be included as part of the extraction</i> ) .....	B/R*
<b><u>Complicated Suturing</u></b> (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)		
D7911	Complicated suture - up to 5 cm.....	B/R*
D7912	Complicated suture - greater than 5 cm .....	B/R*
<b><u>Other Repair Procedures</u></b>		
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	B/R*
D7970	Excision of hyperplastic tissue - per arch .....	B/R*
D7971	Excision of pericoronal gingiva .....	B/R*
<b><u>Orthodontics</u></b>		
<i>(Delta Dental's allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). Delta Dental will make an allowance for the cost of a standard orthodontic treatment when specialized orthodontic appliances or procedures are chosen for aesthetic considerations)</i>		
<b><u>Delta Dental Limited Orthodontic Treatment</u></b>		
D8010	Limited orthodontic treatment of the primary dentition .....	0.00
D8020	Limited orthodontic treatment of the transitional dentition.....	0.00
D8030	Limited orthodontic treatment of the adolescent dentition.....	0.00
D8040	Limited orthodontic treatment of the adult dentition .....	0.00
<b><u>Interceptive Orthodontic Treatment</u></b>		
D8050	Interceptive orthodontic treatment of the primary dentition .....	0.00
D8060	Interceptive orthodontic treatment of the transitional dentition.....	0.00
<b><u>Comprehensive Orthodontic Treatment</u></b>		
D8070	Comprehensive orthodontic treatment of the transitional dentition .....	0.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition .....	0.00
D8090	Comprehensive orthodontic treatment of the adult dentition.....	0.00
<b><u>Minor Treatment to Control Harmful Habits</u></b>		
D8210	Removable appliance therapy .....	0.00
	<i>(This procedure is an orthodontic service only, and is not equivalent to a night guard, occlusal orthotic device, bite guard or occlusal splint which are provided for non-orthodontic purposes)</i>	
D8220	Fixed appliance therapy .....	0.00
<b><u>Other Orthodontic Services</u></b>		
D8660	Pre-orthodontic treatment visit.....	0.00
	<i>(Equivalent to procedure D0150)</i>	
D8670	Periodic orthodontic treatment visit (as part of contract).....	0.00
	<i>(Delta Dental considers periodic treatment visits to be part of, and included in the contracted fees for, limited, interceptive and comprehensive orthodontic treatment)</i>	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s]) .....	0.00
D8690	Orthodontic treatment (alternative billing to a contract fee) .....	0.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers.....	0.00
D8999	Unspecified orthodontic procedure.....	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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#### **Adjunctive General Services**

D9110 Palliative (emergency) treatment of dental pain - minor procedures..... 50.00

#### **Anesthesia**

D9220 Deep sedation/general anesthesia - first 30 minutes ..... 143.00

D9221 Deep sedation/general anesthesia - each additional 15 minutes..... 31.00

D9241 Intravenous conscious sedation/analgesia - first 30 minutes ..... 157.00

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes ..... 29.00

**Professional Consultation** *(Delta Dental considers this procedure to be for a consultation by a specialist whose opinion or advice has been requested regarding a specific problem when routine diagnostic procedures have been performed by a general dentist and the treatment is not provided by the specialist).*

D9310 Consultation - diagnostic service provided by Provider or physician other than requesting Provider  
or physician..... 54.00

#### **Miscellaneous Services**

D9930 Treatment of complications (post-surgical) - unusual circumstances .....B/R\*

\*By Report – Delta Dental will determine the maximum allowance based on a narrative report submitted by the Provider.

**NOTE: The procedures described and allowances indicated on this table are subject to the terms of the Contract and Delta Dental processing policies and may be limited or excluded.**

Note: The above codes and nomenclature are copyright of the American Dental Association. Notes in italic type have been added by Delta Dental for clarification of its processing policies with respect to these procedures and are not part of the ADA's nomenclature.

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## **NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Delta Dental protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program, and we will notify you of how you can receive a copy of this notice every three years.

### **Permitted Uses and Disclosures of Your PHI**

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Delta Dental in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Delta Dental in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

### **Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.  
*For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.  
*For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.  
*For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

### **Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

### **Disclosures Delta Dental Makes With Your Authorization**

Delta Dental will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

### **Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Delta Dental office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your

request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by e-mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

### **Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Delta Dental has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

### **Contact**

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023

Phone: 770-641-5100

**This notice is effective on and after July 1, 2006.**

**Contract Amendment**

**AMENDMENT NO:**

**Group No.:**

*Information on this form is variable*

**IT IS AGREED** that the Contract effective                      between **DENTEGRA INSURANCE COMPANY** and                      is hereby  
**AMENDED** effective                      as follows:

Except as **AMENDED** all terms and provisions of this Contract shall remain unchanged.

---

Signature of Contractholder

**DENTEGRA INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read 'Anthony S. Barth', written over a horizontal line.

Anthony S. Barth, Vice Chairman

SLE-C-AMEND

**Evidence of Coverage Amendment**

**AMENDMENT NO:**

**Group No.:**

*Information on this form is variable*

**IT IS AGREED** that the Contract effective                      between **DENTEGRA INSURANCE COMPANY** and                      is hereby  
**AMENDED** effective                      as follows:

Except as **AMENDED** all terms and provisions of the Certificate shall remain unchanged.

**DENTEGRA INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read 'Anthony S. Barth', with a long horizontal stroke extending to the right.

Anthony S. Barth, Vice Chairman

SLE-E-AMEND

**Dentegra Insurance Company**Alpharetta, GA 30009  
(877) 280-4204**Group Dental Insurance Application**

Dentegra's Use ONLY

Group #: \_\_\_\_\_

AE: \_\_\_\_\_ AM: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_ Fed ID/TIN#: \_\_\_\_\_

Type of Group: \_\_\_\_\_ Type of Industry: \_\_\_\_\_ SIC Code: \_\_\_\_\_

(employer, association, trust: submit association by-laws or trust agreement)

Address: \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

(County)

Name of Contact Person: \_\_\_\_\_ Telephone \_\_\_\_\_

Fax No.: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Billing Address if different:

TPA ☐ No ☐ Yes Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Contact:

Telephone #: \_\_\_\_\_

Contract Effective Date: \_\_\_\_\_ Length of Contract: \_\_\_\_\_

Type of Contract: ☐ Non Retention ☐ Self Funded ("ASC") ☐ Self Funded with Stop Loss \_\_\_\_\_% ☐ Other: \_\_\_\_\_

<b>Program</b> (check one)	<input type="checkbox"/> Dentegra ("PPO") <input type="checkbox"/> Flexible Dual Choice <input type="checkbox"/> Other:															
<b>Fee Basis</b>	<input type="checkbox"/> PPO in/PPO out <input type="checkbox"/> Table of Allowances # _____ <input type="checkbox"/> PPO in/Program Allowance out (Program Allowance: <input type="checkbox"/> Standard <input type="checkbox"/> Other _____)															
<b>Type of Provider</b>	<table border="1"><thead><tr><th>PPO</th><th>Premier</th><th>Non-Delta Dental</th></tr></thead><tbody><tr><td>Diagnostic &amp; Preventive</td><td>_____%</td><td>_____%</td><td rowspan="3"><input type="checkbox"/> Sealants</td></tr><tr><td>Basic</td><td>_____%</td><td>_____%</td><td><input type="checkbox"/> Sealants <input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery</td></tr><tr><td>Major</td><td>_____%</td><td>_____%</td><td><input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery</td></tr></tbody></table>	PPO	Premier	Non-Delta Dental	Diagnostic & Preventive	_____%	_____%	<input type="checkbox"/> Sealants	Basic	_____%	_____%	<input type="checkbox"/> Sealants <input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery	Major	_____%	_____%	<input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery
PPO	Premier	Non-Delta Dental														
Diagnostic & Preventive	_____%	_____%	<input type="checkbox"/> Sealants													
Basic	_____%	_____%		<input type="checkbox"/> Sealants <input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery												
Major	_____%	_____%		<input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Oral Surgery												
<b>Benefit Year</b> (check one)	<input type="checkbox"/> Calendar Year <input type="checkbox"/> Contract Year															
<b>Deductible</b>	\$_____ per Enrollee; \$_____ per Family <b>or</b> \$_____ Lifetime															
<b>Annual Maximum</b>	\$_____															
<b>Orthodontics</b> (check one)	<input type="checkbox"/> not applicable <input type="checkbox"/> adults, children & students <input type="checkbox"/> children and students only <input type="checkbox"/> children only _____%   _____%   _____%   Ortho Max: \$_____   <input type="checkbox"/> Lifetime <input type="checkbox"/> Calendar Yr <input type="checkbox"/> Contract Yr															
<b>Dental Accident Benefit</b>	_____%   _____%   _____%   \$_____ per Enrollee per Benefit Year															
<b>Waiting Period</b> (check all that apply)	<input type="checkbox"/> Basic _____ months   <input type="checkbox"/> Major _____ months   <input type="checkbox"/> Orthodontic _____ months															
Waiting periods are calculated for each Enrollee from: The effective date reported for the Primary Enrollee <input type="checkbox"/> or The effective date reported for each Enrollee <input type="checkbox"/>																
<b>Late Entrant Limitation</b> (check all that apply)	<input type="checkbox"/> yes <input type="checkbox"/> no _____ months   <input type="checkbox"/> Diagnostic & Preventive Sealants <input type="checkbox"/> Basic <input type="checkbox"/> Major <input type="checkbox"/> Ortho <input type="checkbox"/> Dental Accident Benefit include percentages in the Special Request Box below															
<b>Takeover</b> <input type="checkbox"/> yes* <input type="checkbox"/> no If yes, previous carrier & takeover period: _____																
*please check applicable boxes and provide history. <input type="checkbox"/> Deductible Takeover <input type="checkbox"/> Maximum Takeover <input type="checkbox"/> Orthodontic Takeover																
<b>Combined Medical / Dental</b> <input type="checkbox"/> yes <input type="checkbox"/> no If yes, name of other carrier: _____																
<b>Multiple Plan Option</b> <input type="checkbox"/> yes <input type="checkbox"/> no If yes, name of other carrier: _____																
<input type="checkbox"/> yes <input type="checkbox"/> no Missing Tooth Exclusion applies – only teeth extracted under the contract will be covered; <input type="checkbox"/> yes <input type="checkbox"/> no Section 125																
<b>Incentive Plan</b> (check option purchased and include percentages in the Special Request Box below: <input type="checkbox"/> Standard Incentive <input type="checkbox"/> Partial Benefit Incentive (for part-time employees) <input type="checkbox"/> Enrollee-Member Incentive																
<input type="checkbox"/> Special Requests (attach page if necessary):																

(Continued on next page)



**Group Dental Application (Continued)****Applicant's Name:** \_\_\_\_\_**Employer Contribution:** ☐ percentage ☐ dollar amount For Employee: \_\_\_\_\_ For Dependent: \_\_\_\_\_**Monthly Rates:**

☐ Two Tier: EE: \$ \_\_\_\_\_ EE & family: \$ \_\_\_\_\_  
☐ Three Tier: EE: \$ \_\_\_\_\_ Two Party: \$ \_\_\_\_\_ Three Party: \$ \_\_\_\_\_  
☐ Four Tier: EE: \$ \_\_\_\_\_ EE & Spouse: \$ \_\_\_\_\_ EE & child(ren): \$ \_\_\_\_\_ EE, Spouse & Child(ren): \$ \_\_\_\_\_  
☐ Other (specify type and amount): \_\_\_\_\_ If ASC: Per primary member \$ \_\_\_\_\_ per month *or* \_\_\_\_\_ % of claims per month

**Census:** \_\_\_\_\_ # of Eligible Employees  
\_\_\_\_\_ # of Employees Participating in Dentegra's Dental Program

**Eligibility:** # of Months: \_\_\_\_\_ or # of Days: \_\_\_\_\_ Hours / week: \_\_\_\_\_

**Employee Effective Date:** ☐ 1<sup>st</sup> day of the month following completion of eligibility ☐ Date of hire  
☐ 1<sup>st</sup> day of month following date of hire ☐ Day following completion of eligibility

**Who is eligible:** ☐ All Employees ☐ Class of employees: \_\_\_\_\_  
☐ Retired Employees Children to age: \_\_\_\_\_ Students to age: \_\_\_\_\_

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Dentegra. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Dentegra we would not in good faith have issued the contract at the same premium rate. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Dentegra with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental services contract for which Applicant is applying. Dentegra agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental contract or as permitted or required by law. Applicant and Dentegra shall comply with all the applicable federal and state laws and regulations relating to administrative simplification, security and privacy of PHI, including the terms of any business associate addendum that may be required as part of the group dental contract to be executed between Applicant and Dentegra.

☐ Applicant understands he/she will receive an electronic version of the evidence of coverage booklet for distribution to all employees/ members covered under the contract.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ for the Applicant at: \_\_\_\_\_  
*City and State*

By: \_\_\_\_\_ Signature: \_\_\_\_\_  
*(please print – name and title)*

*Accepted for Dentegra Insurance Company*

This \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Authorization \_\_\_\_\_ initials \_\_\_\_\_

\_\_\_\_\_  
Anthony S. Barth, Vice Chairman, Dentegra Insurance Company

**Agent Information**

Agent Name \_\_\_\_\_ TIN or SS# \_\_\_\_\_ Are you appointed with Dentegra Insurance Company? ☐ yes ☐ no  
State license # \_\_\_\_\_ *(if applicable)*  
Signature \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_  
(Street) (City) (State) (zip) (County)



## APPENDIX TO THE GROUP APPLICATION

*Information on this page is variable*

Contract #: [d1]

For: [d2]

(Name of Group)

**IT IS AGREED** that the Application between **DENTEGRA INSURANCE COMPANY** and [d3] is hereby **AMENDED** as follows:

[d4]

Except as **AMENDED** all terms and provisions of the Group Application shall remain unchanged.

**DENTEGRA INSURANCE COMPANY**

Anthony S. Barth, Vice Chairman

*SERFF Tracking Number:*      *DDPA-126229677*

*State:*      *Arkansas*

*Filing Company:*      *Dentegra Insurance Company*

*State Tracking Number:*      *42939*

*Company Tracking Number:*      *SLE-GRP-09-004*

*TOI:*      *H10G Group Health - Dental*

*Sub-TOI:*      *H10G.000 Health - Dental*

*Product Name:*      *SLE-GRP-AR*

*Project Name/Number:*      */*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number:	DDPA-126229677	State:	Arkansas
Filing Company:	Dentegra Insurance Company	State Tracking Number:	42939
Company Tracking Number:	SLE-GRP-09-004		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	SLE-GRP-AR		
Project Name/Number:	/		

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Flesch Certification	<b>Review Status:</b>	Approved-Closed	07/24/2009
<b>Comments:</b>	Please see attached a signed readability/flesch certification letter.			
<b>Attachment:</b>	[Untitled]-2009071506021587.pdf			

<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	07/24/2009
<b>Bypass Reason:</b>	Please see the Application attached in the Forms section.			
<b>Comments:</b>				

<b>Satisfied -Name:</b>	Enrollment Form	<b>Review Status:</b>	Approved-Closed	07/24/2009
<b>Comments:</b>	Please see attached the Enrollment Form that is to be used with the submitted documents.			
<b>Attachment:</b>	DIC Form 3464 ST.pdf			

<b>Satisfied -Name:</b>	Variable Information Forms	<b>Review Status:</b>	Approved-Closed	07/24/2009
<b>Comments:</b>	Please see attached forms with variable information and comments.			
<b>Attachments:</b>	G-SLE-C-AR-09w comments.pdf			
	C-AMEND w comments 071009.pdf			
	E-AMEND w comments071009.pdf			
	AX-G-AP w comments.pdf			
	G-SLE-E-AR-09w comments.pdf			



www.dentegra.com

## **Readability/Flesch Certification**

### **Arkansas Regulation 49**

This document certifies that the submitted forms achieved your state's minimum statutory requirements relating to readability.

<b>Form No:</b>	<b>Readability Score</b>
G-SLE-C-AR-09	52
SLE-C-AMEND	61
G-SLE-E-AR-09	52
SLE-E-AMEND	61
SLE DENTEGRA-GRP-AP	N/A
SLE-AX-G-AP	61

Paul Lambert  
Name

Paul Lambert  
Signature

Vice President, of Underwriting  
Title

7-15-09  
Date



# ENROLLMENT/CHANGE FORM

Dentegra Insurance Company

Dentegra Insurance Company  
[Street]  
[City, State, Postal code]  
www.dentegra.com

VERY IMPORTANT - Please Print Legibly

## Enrollee/Change Information

- ☐ New Enrollment ☐ Marital Status Change ☐ Terminate Enrollee Coverage ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- ☐ Add/Delete Dependent ☐ Address Change ☐ Other \_\_\_\_\_

## Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
First Name	Last Name	Middle Initial		
Mailing Address (Street)	City	State	ZIP Code	
E-mail Address (internal use only)	Phone Number ( ) -	Phone Type	Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>	
Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth	/ /	
Effective Date of Other Policy / /	Policy Holder Street Address	City	State	ZIP Code

## FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

## Enrollee Classification

- ☐ Full-Time ☐ Hourly ☐ Certified
- ☐ Part-Time ☐ Salaried ☐ Classified
- ☐ Retired ☐ Member/Other \_\_\_\_\_

## COBRA (if applicable)

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce/Legal Separation\*
- ☐ Widowed/Surviving Dependent\*
- ☐ Dependent Child No Longer Eligible\*
- Indicate qualifying date: / /
- \*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.**

## Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. \*\*Additional documentation will be required for disabled and student status.

- ☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

- ☐ I decline coverage at this time.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Signature of Enrollee \_\_\_\_\_

Date / /

**DENTEGRA INSURANCE COMPANY**

1130 Sanctuary Parkway  
Suite 600  
Alpharetta, Georgia 30009  
(877) 280-4204

**Group Dental PPO Insurance Contract**

[Group's Name][D1], ("Contractholder") has applied for a group dental insurance Contract with Dentegra Insurance Company (Dentegra). The following terms will apply:

- I. Contractholder will pay Dentegra the monthly Premium stated in this Contract.
- II. Dentegra has accepted the Application submitted by the Contractholder. A copy is attached and made a part of this Contract. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Appendix A. The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.
- III. [Contractholder][D2] will give each Primary Enrollee a certificate furnished by Dentegra. [Contractholder][D3] will give each Primary Enrollee electronic access to a certificate of coverage furnished by Delta Dental.] Contractholder will also distribute to its Enrollees any notice from Dentegra which affects their rights under this Contract.

So long as Contractholder pays the Premiums stated in Article 3, Dentegra agrees to provide the Benefits described in Article 4. This Contract will continue from year to year until terminated, as stated in Article 8.

This Contract is issued and delivered in the State of Arkansas and is governed by its laws.



**Anthony S. Barth, Vice Chairman**

**UNDERWRITTEN BY:**

**DENTEGRA INSURANCE COMPANY**

1130 Sanctuary Parkway, Suite 600  
Alpharetta, Georgia 30009  
(877) 280-4204

**ADMINISTERED BY:**

**DELTA DENTAL INSURANCE COMPANY**

1130 Sanctuary Parkway, Suite 600  
Alpharetta, Georgia 30009  
(770) 641-5100

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## ARTICLE 1 DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

- 1.01 **Accepted Fee** -- the amount the attending Provider agrees to accept as payment in full for services rendered.
- 1.02 **Benefits (In-Network or Out-of-Network)** -- the amounts that Delta Dental will pay for dental services under this Contract. In-Network Benefits are those covered by this Contract and performed by a Delta Dental PPO<sup>SM</sup> Provider. Out-of-Network Benefits are those covered by this Contract but performed by a Delta Dental Premier<sup>®</sup> Provider or a Non-Delta Dental Provider.
- 1.03 **Claim Form** -- the standard form used to file a claim or request a Pre-Treatment Estimate for treatment.
- 1.04 **Contract** -- this agreement between Delta Dental and Contractholder, including the Application and the attachments listed in Article 9.
- 1.05 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied.
- 1.06 **Contractholder** -- the employer, union or other organization or group contracting to obtain Benefits.
- 1.07 **Contract Term** -- the period during which this Contract is in effect, as shown in Appendix A.
- 1.08 **Contract Year** -- [the 12 months] starting on the Effective Date and each subsequent [12] month period thereafter. [d4] Deductibles and maximums will be determined using this [12] month period rather than on a Calendar Year basis [D5].
- 1.09 **Deductible** -- a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.
- 1.10 **Delta Dental** -- means collectively, Dentegra Insurance Company and Delta Dental Insurance Company providing and/or administering dental benefit programs. For the purposes of this Contract, Dentegra Insurance Company is the underwriter and Delta Dental Insurance Company is the administrator.
- 1.11 **Delta Dental Premier Provider (Premier Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under a plan and complies with Delta Dental's administrative guidelines.
- 1.12 **Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee)** -- the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating Enrollees.
- 1.13 **Delta Dental PPO Provider (PPO Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under this PPO dental plan and complies with Delta Dental's administrative guidelines.
- 1.14 **Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee)** -- the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating Enrollees.
- 1.15 **Dependent Enrollee** -- an Eligible Dependent enrolled to receive Benefits.
- 1.16 **Effective Date** -- the date the program starts, as shown in Appendix A.
- 1.17 **Eligible Dependent** -- a dependent of an Eligible Employee [or domestic partner [D6]] eligible for Benefits under Article 2.
- 1.18 **Eligible [Employee/Member]** [d7] -- any [employee/member] [or retiree [D8]] as eligible for Benefits under Article 2.
- 1.19 **Enrollee** -- an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".
- 1.20 **Enrollee's Effective Date of Coverage** -- the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.
- 1.21 **Maximum Contract Allowance** -- the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [by a PPO Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or

- by a Premier Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
  - by a Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee[d9] for a PPO Provider in the same geographic area.
  - [by a PPO Provider is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
  - by a Premier Provider is the lesser of the Submitted Fee on the claim or the Premier Provider's Contracted Fee; or
  - by Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the Program Allowance][d10].]
  - [by a PPO Provider is the lesser of the Submitted Fee on the claim, the PPO Provider's Contracted Fee or the amount shown on the Table of Allowance; or
  - By a Premier Provider is the lesser of the Submitted Fee on the claim, the Premier Provider's Contracted Fee or the amount shown on the Table of Allowance; or
  - by a Non-Delta Dental Provider is the lesser of the Submitted Fee on the claim or the amount shown on the Table of Allowances.[d11]]
- 1.22 **Non-Delta Dental Provider** -- a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Delta Dental's administrative guidelines and has not agreed to accept the contracted fees.
- 1.23 **Open Enrollment Period** -- the month of the year during which employees may change coverage for the next Contract Year.
- 1.24 **Patient Pays** -- Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.
- 1.25 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Enrollee.
- 1.26 **Premium** -- the amounts payable by the Contractholder as provided in Appendix A.
- 1.27 **Primary Enrollee** -- an Eligible Employee enrolled in the plan to receive Benefits.
- 1.28 **Procedure Code** -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.
- 1.29 **Program Allowance** -- the amount determined by Delta Dental for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.
- 1.30 **Provider** -- a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.
- 1.31 **Qualifying Status Change** -- a change in:
- legal marital status (marriage, divorce, legal separation, annulment or death);
  - number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
  - employment status (change in employment status of Enrollee, spouse or dependent child);
  - dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
  - residence (Enrollee, dependent spouse or child moves);
  - a court order requiring dependent coverage; or
  - any other current or future election changes permitted by IRC Section 125.
- 1.32 **Single Procedure** -- a dental procedure that is assigned a separate CDT® number.
- 1.33 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.
- 1.34 **[Table of Allowances][D12]** -- the list of covered dental services showing the Procedure Code and the maximum amount paid by for each covered Single Procedure. The Table of Allowances is attached as Appendix B.]

## ARTICLE 2 ELIGIBILITY AND ENROLLMENT

- 2.01 **Reporting**  
[On or before the Effective [D13] Date, Contractholder will furnish to Delta Dental, in writing or in electronic media format agreed by Delta Dental and the Contractholder, a listing of eligible Primary Enrollees and Dependent Enrollees. The listing shall include but not be limited to the:
- Primary Enrollees and Dependent Enrollees: names, Enrollee ID numbers, dates of hire, Effective Date of coverage, dates of birth, addresses and gender
  - Dependent Enrollees dependent status; and
  - Primary Enrollees location, if applicable.

The eligibility list shall include all active employees unless the employee waives coverage or the Eligible Employee enrolls in an alternate dental plan offered by Contractholder. [The eligibility list may also include retired employees and surviving spouses of employees.]

Thereafter, before the 10<sup>th</sup> [d14] of each month, Contractholder must furnish to Delta Dental in the format agreed to above, a listing indicating specific additions, changes or terminations made during the prior month.] An Enrollee remains enrolled until the Contractholder notifies Delta Dental of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, Contractholder must promptly notify Delta Dental of such change.

[If [d15] the Contractholder will report eligibility through Delta Dental's web site, on or before the Effective Date, Contractholder will furnish Delta Dental with an initial report of eligible Primary Enrollees by transmitting all of the Enrollee information as requested by the eligibility update section of the web site. Once Contractholder transmits the Enrollee information through Delta Dental's web site, the information for each Enrollee shall remain effective from the Effective Date of the information until the earlier of the termination of the Enrollee's coverage or the expiration of a Contract Term. An Enrollee remains enrolled until the Contractholder notifies Delta Dental of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, Contractholder must promptly transmit such change via the web site. Contractholder may only use the electronic mail link and accompanying form Delta Dental provides for changes listed on the form. Such revised information shall remain effective until the earlier of the termination of the Enrollee's coverage or the next renewal update by the Contractholder. For renewal of the Contract Term, Contractholder must review and update as necessary all Enrollee information. Contractholder agrees to install and implement any desktop upgrades and/or configuration changes necessary to continue to update Eligibility information. Contractholder agrees to comply with Delta Dental policies and requirements as posted on the Delta Dental web site when accessing or updating information on the Delta Dental web site. Contractholder is responsible for: (1) maintaining the confidentiality of any passwords or other information required to access the Delta Dental web site information; (2) the accuracy of all information that Contractholder provides to Delta Dental through its web site, and; (3) any Contractholder delays in submitting information to Delta Dental through its web site.]

Contractholder will notify Delta Dental in writing or in electronic media of any requests for Premium adjustments for Enrollees who should have been terminated in the event Delta Dental was not previously notified of the termination(s). Retroactivity will be adjusted to the immediately preceding 3 months plus the current billing month.

Delta Dental will not make any payment for services provided to an Enrollee who is not reported to Delta Dental as an Enrollee under this Contract when the service is provided. Also, Delta Dental may not pay Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Delta Dental shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse Delta Dental for any erroneous claim payments made by Delta Dental as a result of incorrect eligibility reporting by the Contractholder.

- 2.02 Contractholder will permit Delta Dental to audit Contractholder's records to check whether the lists of Primary and Dependent Enrollees are correct and to confirm compliance with Article 3. Delta Dental will give Contractholder written notice within a reasonable time before the audit date.
- 2.03 **Eligible Employees** [d16]  
Eligible Employees are full-time employees as indicated on the attached Application. Eligible Employees will become eligible to receive Benefits on the date stated on the attached Application after completing any eligibility periods required by the Contractholder as stated in the attached Application.
- 2.04 **Eligible Dependents**  
Eligible Dependents of an Eligible Employee are:
- Lawful spouse [or Domestic Partner named in Contractholder's Affidavit of Domestic Partnership] [d17].
  - An unmarried child from birth [to their/end of month of 19th birthday or 25<sup>th</sup> birthday] [d18] if a full-time student in an accredited school. Proof of full-time student status must be given to Delta Dental within 60 days when requested. "Children" include natural children, step-children, adopted children, [children of the domestic partner [d19]], foster children and children for which the employee has been appointed legal guardian. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. [However, [d20] the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any [Contract/Calendar [d21]] Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the [Contract/Calendar [d22]] Year immediately following said child's fourth birthday.]
  - An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is mostly dependent on the Eligible Person for support and maintenance. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible.

## 2.05 Enrollment of Eligible Employees and Eligible Dependents

- If [D23] Contractholder pays the entire cost of coverage for all Primary Enrollees [and Dependents Enrollees [D24]], all Eligible Employees [and Eligible Dependents [D25]] are automatically covered under the plan. If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. If coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, the Primary Enrollee may not re-enroll except during an Open Enrollment Period. [D26]  
If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change [D27].
- If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. If Dependent Enrollees coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, then former Dependents-Enrollees may not be re-enrolled at any time, unless there is a court order requiring dependent coverage [D28].  
If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change [D29].  
If the Primary Enrollee is paying all of the cost for Dependent Enrollees' coverage in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. However, the eligibility date for young children, under the age of four (4), may be delayed until the beginning of any [Contract/Calendar [D30]] Year including the [Contract/Calendar [D31]] Year immediately following said child's fourth birthday. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change [D32].
- If both spouses are Eligible Employees, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee [D33].  
If both spouses are Eligible Employees, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees [D34].  
If both spouses are Eligible Employees, one may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee [D35].  
If both spouses are Eligible Employees, one may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees [D36].
- All Eligible Dependents [not covered under another group plan [D37]] must be enrolled as Dependent Enrollees if dependent coverage is elected.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under this Contract as a Primary Enrollee or a Dependent Enrollee but not both at the same time.

## 2.06 Late Entrant Provision

[A Late Entrant is an Eligible Employee and/or his/her Eligible Dependents who do not enroll for coverage under this Contract within [31] days of the date first eligible, but later become covered. A Late Entrant may also include a person who requests coverage for him/herself and/or his/her Eligible Dependents which was terminated while he/she remained eligible for coverage under this Contract. Benefits for Late Entrants are reduced as shown on Appendix A [d38].]

- 2.07 [Except for an employee absent from work due to a leave of absence [approved by the Contractholder or [D39]] governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), an Enrollee will not be covered for any dental services received while a Primary Enrollee is on strike, lay-off or leave of absence. Contractholder must inform Delta Dental of any change in eligibility as required under section 2.01.

Benefits for such Primary Enrollee and his/her Eligible Dependents will resume as follows:

- If coverage is reactivated in the same [Contract/Calendar [D40]] Year, Deductibles and maximums will resume as if the Primary Enrollee were never gone.
- If coverage is reactivated in a different [Contract/Calendar [D41]] Year, new Deductibles and maximums will apply.

[Coverage will resume the first day of the month after the Primary Enrollee returns to work, provided the Contractholder submits the request to Delta Dental that coverage be reactivated [D42].

[Coverage will resume the date the Primary Enrollee returns to work, provided the Contractholder submits the request to Delta Dental that coverage be reactivated [D43].]

If an employee is rehired within the same [Contract/Calendar [D44]] Year, Deductibles and maximums will resume as if the Primary Enrollee was never gone [d45].]

- 2.08 [A Primary Enrollee loses coverage on the last day of the month [of employment /he is no longer an Eligible Member of the Contractholder/he stops paying the required Premiums for coverage [d46]] or on the day this Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee or dependent status is lost [D47].]



[A Primary Enrollee loses coverage on the day [of termination of employment/he is no longer an Eligible Member of the Contractholder/he stops paying the required Premiums for coverage[d48]] or on the day this Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee or dependent status is lost[D49].]

*Termination of Benefits on Loss of Eligibility*

Delta Dental will not pay for Benefits for any services received by a person who is not an Enrollee at the time of treatment except for covered services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

2.09 **[Continued Coverage Under USERRA]**

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if a Primary Enrollee is covered by this Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date the Primary Enrollee fails to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage[d50].

2.10 **[Continuation of Coverage Under COBRA]**

When the Eligible Employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Delta Dental agrees to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- Continuation of coverage is required to be offered under COBRA;
- The Enrollee requests the continuation within the time frame allowed;
- The Contractholder notifies Delta Dental that the Enrollee has elected to continue coverage under COBRA;
- Delta Dental receives the required Premium for the continued coverage;
- This Contract stays in force.

Delta Dental does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA[d51]).]

2.11 **[Multiple Plan Options [D52]**

This Contract is entered into with the understanding that Eligible Employees of the Contractholder have a choice between dental coverage under this Delta Dental plan and one or more alternate programs. Eligible Employees may exercise that choice as follows:

- All Eligible Employees that enroll will be enrolled as Primary Enrollees under the Delta Dental plan unless they elect an alternate plan.
- Except for new employees, enrollment may be filed with Contractholder only during the Open Enrollment Period.
- New employees may enroll within 31 days of employment which will be effective until the next Open Enrollment Period.]

2.12 **[Parallel Enrollment [D53]**

Eligible Employees and Eligible Dependents who enroll in the Contractholder's medical plan are required to enroll under this dental plan. Eligibility for coverage under this dental plan begins on the date eligibility under the medical plan begins provided that the Eligible Employee has met the eligibility period requirements shown in Appendix A.]

2.13 **[Flexible Dual Choice [D54]**

This Contract is entered into with the understanding that Eligible Employees of the Contractholder have a choice between dental coverage under this Delta Dental plan and Delta Dental's prepaid dental plan (DeltaCare<sup>®</sup> USA). The Primary Enrollee and his/her covered dependents may move from this PPO plan to the DeltaCare USA plan or from the DeltaCare USA plan to this PPO plan on a monthly basis. The Primary Enrollee and his/her covered dependents will only be covered under one plan at a time. Dental plan changes will be effective the first day of the following month. The Benefits, Limitations and Exclusions listed in this booklet apply when the Enrollee is covered under the PPO plan.]

### ARTICLE 3 MONTHLY PREMIUMS

3.01 Contractholder will remit the monthly Premium in the amount and manner shown in Appendix A for all Primary Enrollees and Dependent Enrollees.

[Contractholder will remit a full month's Premium for Enrollees whose coverage is effective on the first (1st) through the 15th calendar day of a month. Premiums are not due to Delta Dental for Enrollees who are enrolled on the 16th through the last day of a month.]

Contractholder will remit a full month's Premium for Enrollees whose coverage is terminated on the 16th through the last calendar day of a respective month. Premiums are not due to Delta Dental for Enrollees whose enrollment is terminated on the first (1st) through the 15th day of a month.][D55]

- 3.02 [This Contract will not be in effect until Delta Dental receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 31 days from the due date will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Delta Dental in accordance with the notice requirements of Section 8.01. Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the current three (3) month U.S. Treasury Bill rate.[D56]]
- [Contractholder[d57] will pay all Premiums, including the first month's Premium, to Delta Dental within [60[D58]] days following the first calendar day of the applicable month of coverage. This [60][d59] day period includes a 31 day grace period. This Contract will continue in force during this period. However, if the Premium remains unpaid at the end of this period, Delta Dental may terminate this Contract in accordance with the notice requirements of Section 8.01. Any payment received after 90 days of the due date shall be subject to interest equal to one percentage point above the current three (3) month U.S. Treasury Bill rate.]
- 3.03 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 8.
- 3.04 Delta Dental will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.
- 3.05 Delta Dental may change the rate of monthly Premium whenever the Contract is amended, [as stated in Article 3.06,] [D60] or whenever the Contractholder requests a change in Benefits. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Delta Dental agree in writing, [except as provided in Articles 3.06 and 3.07]. [D61]
- 3.06 [D62] Premiums are based on the number of covered employees at the beginning of each Contract Term. If the Contractholder reports a [15[D63]] percent addition or reduction in the number of covered Primary Enrollees for three (3) months in a row, Delta Dental may propose a choice of changes in Premiums or Benefits to remedy the increase in cost per person which may result from the difference in the number of enrolled employees. Within 31 days, Contractholder will select one of the choices by written notice to Delta Dental. If Contractholder fails to do so, Delta Dental may select one of the choices by written notice to Contractholder. This Contract will be modified for all dental services predetermined and paid after notice.
- 3.07 If during the Contract Term any new or increased tax is imposed on the amounts payable to Delta Dental under this Contract, the amount stated in Appendix A will be increased by the amount of any such new or increased taxes.

#### ARTICLE 4 BENEFITS, LIMITATIONS AND EXCLUSIONS[D64]

- 4.01 Subject to the limitations and exclusions in this Contract, Delta Dental will pay the Benefits stated for each type of dental service described below when provided by a Provider and when necessary and customary under generally accepted dental practice standards and applicable Benefits. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, for specific services are shown in Appendix A. If an Enrollee receives dental services from a Provider outside the state of Arkansas, the Provider will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract.
- If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- 4.02 No change in Benefits will become effective during a Contract Term unless Contractholder and Delta Dental agree in writing.
- 4.03 **Enrollee Coinsurance**  
Delta Dental's provision of Benefits is limited to the applicable portion of Provider's fees or allowances specified [in Appendix A/below[d65]]. The Enrollee is responsible for paying the balance of any fees or allowances known as the "Enrollee Coinsurance". Contractholder has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such fees or allowances that are discounted, waived or rebated.

#### 4.04 Benefits

[Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Appendix A of the Maximum Contract Allowance for the following services[d66].]

- **Diagnostic and Preventive Benefits**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit[D67] for payment purposes), topical application of fluoride solutions, space maintainers.
- (3) [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay[D68].]

- **Basic Benefits**

- (1) [Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care[D69]).]
- (2) General Anesthesia or IV Sedation: when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
- (3) [Endodontics: treatment of diseases and injuries of the tooth pulp[D70].]
- (4) [Periodontics: treatment of gums and bones supporting teeth[D71].]
- (5) Palliative: emergency treatment to relieve pain.
- (6) [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay[D72].]
- (7) [Restorative: amalgam, synthetic porcelain and plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay[D73]).]
- (8) [Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining[D74].]

- **Major Benefits**

- (1) [Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care[D75]).]
- (2) [Endodontics: treatment of diseases and injuries of the tooth pulp[D76].]
- (3) [Periodontics: treatment of gums and bones supporting teeth[D77].]
- (4) [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations[D78].]
- (5) [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation[D79].]

- **[Orthodontic Benefits[D80]**

Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.]

- **[Temporomandibular Joint Dysfunction (TMJ) Benefits[D81]**

Intra-oral services provided by a licensed Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofascial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).]

- **[Implant Benefits[D82]**

Procedures performed by a Provider for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis.]

- **[Dental Accident Benefits**

An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and stayplate[d83].]

**Note on additional Benefits during pregnancy** - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each [12 month period, Calendar Year, Contract Year[D84]] while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

#### 4.05 Limitations on All Benefits - Optional Services

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth; or
- a precision denture/partial where a standard denture/partial could be used; or
- an inlay/onlay instead of an amalgam restoration; or
- porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown) [; or/.][d85]
- [a composite restoration instead of an amalgam restoration on posterior teeth.][D86]

If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

#### 4.06 Limitations

##### • Limitations on Diagnostic and Preventive Benefits:

- (1) Delta Dental will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) and topical application of fluoride solutions no more than [twice in any 12 month][D87]. Note that periodontal cleanings are covered as a [Basic Benefit] [d88] and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- (2) Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- (3) X-ray limitations:
  - a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
  - d) A complete intraoral series and panoramic film by the same Provider/Provider office are each limited to once every [five (5)][d89] years.
  - e) Bitewing x-rays [d90] are limited to [two (2) times in any 12 month period] when provided to Enrollees under 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries.
- (4) [Topical application of fluoride solutions is limited to Enrollees to age 19][D91].
- (5) Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14][D92]. For enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridge or removable partial denture can be placed.
- (6) Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when orthodontic services are a covered Benefit.
- (7) Sealants are limited as follows:[D93]
  - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
  - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application.][D94]

##### • Limitations on Basic Benefits

- (1) Sealants are limited as follows:[D95]
  - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
  - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application[d96].]
- (2) Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months][D97] of treatment if the service is provided by the same Provider/Provider Office.
- (3) Delta Dental limits payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a [Major Benefit.][DJS98]



- (4) [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider/Provider office[d99].]
  - (5) [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing. See note on additional Benefits during pregnancy[d100].]
- **Limitations on Major Benefits**
    - (1) Crowns and inlays/onlays are covered not more often than once in any five (5) year period[D101] except when Delta Dental determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
    - (2) Prosthodontic appliances [and/or implants[d102]] that were provided under any Delta Dental program will be replaced only after five (5) years[D103] have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prostheses not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. [Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental will not pay for bone grafts provided with implants on the same day of service. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.]
    - (3) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
    - (4) Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
    - (5) [The initial installation of a prosthodontic appliance [and/or implants][DJS104] is not a Benefit unless the prosthodontic appliance [and/or implant][DJS105], bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was[d106] ] [under a Delta Dental program / or Contractholder's prior plan[D107]]
    - (6) Delta Dental limits payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement.
      - a) Denture rebase is limited to one (1) per arch in a 24 month period.
      - b) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
    - (7) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture[d108].]
  - **Limitations on Orthodontic Benefits[D109]**
    - (1) The maximum amount payable for each Enrollee during the [Enrollee's lifetime/Calendar/Contract Year[d110]] as shown in Appendix A.
    - (2) Orthodontic Benefits will be provided in two (2) payments after the person becomes covered[d111], (the initial payment at the bonding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months or less, one (1) payment will be made.
    - (3) Benefits are not paid to repair or replace any orthodontic appliance received under this program.
    - (4) Benefits are not paid for orthodontic retreatment procedures.
    - (5) Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Contract Benefit Level and maximum if covered as Benefits under Delta Dental's standard processing policies.
    - (6) [Orthodontic Benefits are limited to dependent child Enrollees [D112]under the age of 19 or [25 if full-time student]].
  - **Limitations on TMJ Benefits:[D113]**
    - (1) TMJ Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Contract.
    - (2) Delta Dental will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health program which provides TMJ Benefits.
    - (3) Benefits are limited to those intra-oral services which would normally be provided by a licensed Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
    - (4) Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this program are excluded.
    - (5) Any procedure paid under any other category of Benefits by this Contract is not covered as a TMJ Benefit.]
  - **Limitations on Implant Benefits:[D114]**

- (1) Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Contract. Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
- (2) Delta Dental will not pay to replace any implant that the Enrollee received in the previous five (5) years.
- (3) Delta Dental will not pay for bone grafts provided with implants on the same day of service.
- (4) Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- (5) Prosthodontic devices and procedures associated with, but not included within the definition of "Implants" are not subject to the Implant Maximum.]

- **[Limitations on Dental Accident Benefits:[D115]**

- (1) The dental accident must occur while the Enrollee is covered under this Contract.
- (2) Services and procedures must be provided within 180 days following the dental accident and while the Enrollee is covered under this Contract.]

#### 4.07 Exclusions

**Delta Dental does not pay Benefits for:**

- treatment of injuries or illness covered by workers' compensation or employers' liability laws, services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.
- maxillofacial prosthetics.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- any Single Procedure started prior to the date the Enrollee became eligible for services under this program.
- prescribed drugs, medication, pain killers, antimicrobial agents, or experimental procedures.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- fixed bridges and removable partials for enrollees under age 16.
- interim implants.
- resin-based inlays and onlays.
- overdentures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- services or supplies covered by any other health plan of the Contractholder.

- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [the initial placement of any prosthodontic appliance [or implants[D116]], unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Contract or was covered under [any dental care program with Delta Dental / the Contractholder's prior dental plan[D117]]. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth[D118].]
- services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefit section, if applicable.
- procedures performed for the purpose of orthodontic treatment except as provided under Orthodontic Benefits, if applicable.
- services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ) except as provided under the TMJ Benefit section, if applicable.
- [services[d119] for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.]
- [services not included on the Table of Allowances[d120].]
- [services or supplies for oral surgery, general anesthesia or IV sedation, palliative treatment, or sealants[D121].]
- [services or supplies for endodontic treatment[D122] (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth[D123]).]
- [services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).][D124]
- [services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).][D125]
- [services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.][D126]
- [services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).][D127]

## ARTICLE 5

### DEDUCTIBLE, MAXIMUM AND COORDINATION OF BENEFITS

#### 5.01 Deductible

[As shown on Appendix A, Delta Dental will not pay Benefits for the Deductible amount of the Maximum Contract Allowance for services received each [Contract/Calendar[D128]] Year by an Enrollee. The annual maximum Deductible per family, if any, is shown in Appendix A. Only fees an Enrollee pays for services that are described under Article 4 will count toward the Deductible[D129].]

[Delta Dental will not pay Benefits for the Deductible amount shown in Appendix A of the Maximum Contract Allowance for services received until the lifetime Deductible has been satisfied by the Enrollee while covered under a Delta Dental plan. Only fees an Enrollee pays for services that are described under Article 4 will count toward the Deductible[D130].]

#### 5.02 Maximum

Delta Dental will pay the maximum amount(s) shown in Appendix A for Benefits under this Contract.

#### 5.03 Coordination of Benefits

[Delta Dental [D131] coordinates the Benefits under this Contract with an Enrollee's Benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. Benefits under one of the plans may be reduced so that combined coverage does not exceed the Provider's total fees for covered services. If this is the "primary" plan, Delta Dental will not reduce Benefits, but if the other Plan is the primary one, Delta Dental will reduce

Benefits otherwise payable under this Contract. The reduction will be the amount paid for or provided under the terms of the primary plan for covered services under Article 4.]

[Delta Dental [D132] coordinates the Benefits under this Contract with an Enrollee's Benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. Benefits under this plan may be reduced so that combined coverage does not exceed Delta Dental's Maximum Contract Allowance. If this is the "primary" plan, Delta Dental will not reduce Benefits, but if the other Plan is the primary one, Delta Dental will reduce Benefits otherwise payable under this Contract. The reduction will be the amount paid for or provided under the terms of the primary plan for covered services under Article 4.]

*Order of Benefit Determination Rules:*

The following rules determine which plan is the "primary" plan:

- If the other Plan is not primarily a dental plan, this Plan is primary, except the Enrollee's medical plan, if any, will be primary for oral surgery procedures covered under such plan.
- If the other Plan is a dental plan, the following rules are applied:
  - (1) The Plan covering the Enrollee as an employee is primary over a Plan covering the Enrollee as a dependent.
  - (2) The Plan covering the Enrollee as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - a) Secondary to the Plan covering the insured person as a dependent and
    - b) Primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the Benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
  - (3) Except as stated in paragraph (4), when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    - a) The Benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the Benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
  - (4) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the Benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the Benefits of any other policy which covers the child as a dependent child.
  - (5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).
  - (6) The Benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this Rule (6) is ignored.
  - (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
    - a) First, the Benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
    - b) Second, the Benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of Benefits, this rule is ignored.
  - (8) If none of the above rules determine the order of Benefits, the Benefits of the Plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

## ARTICLE 6 CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

### 6.01 Choice of a Provider

Enrollees may choose a Provider from Delta Dental's panel of PPO and Premier Providers or Enrollees may choose a Non-Delta Dental Provider. A list of PPO and Premier Providers can be obtained by accessing the Delta Dental National Dentist Directory at [www.deltadentalins.com](http://www.deltadentalins.com). Enrollees are responsible for verifying whether the selected Provider is a PPO Provider or a Premier Provider. Providers are regularly added to the panel. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating PPO Provider or Premier Provider

*PPO Provider*

The PPO program potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

#### Premier Provider

The Premier Provider, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if Enrollees use a Non-Delta Dental Dentist

#### Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by the PPO Providers or Premier Providers. For a Non-Delta Dental Provider, the Accepted Fee is the Provider's submitted charge.

#### Additional advantages of using a Delta Dental Provider:

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider has contractually agreed to charge no more than his/her Delta Dental Provider's Contracted Fee even for services that are not covered under this Contract provided the service(s) are included in his/her agreement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

An Enrollee may also access Delta Dental's Provider Directory on the Internet. Delta Dental's Internet address is [www.deltadentalins.com](http://www.deltadentalins.com). An Enrollee may choose any Provider, but Delta Dental does not guarantee that any particular Provider will be available. The Enrollee is responsible for verifying whether the treating Provider is a PPO or Premier Provider.

#### 6.02 Clinical Examination

Before approving a claim, Delta Dental may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Delta Dental may require to administer the claim. Delta Dental may also require that an Enrollee be examined by a dental consultant retained by Delta Dental in or near his/her community or residence. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

#### 6.03 Notice of Claim Forms

Delta Dental will furnish to any Provider or Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the form must be completed and signed by the Provider who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Delta Dental at the address shown thereon. If Delta Dental does not furnish the form within 15 days after requested by a Provider or Enrollee, the requirements for proof of loss set forth in section 6.05 of this Contract will be deemed to have been complied with upon the submission to Delta Dental within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Enrollees may download a Claim Form from Delta Dental's web site.

#### 6.04 Pre-Treatment Estimate

A Provider may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

#### 6.05 Written Notice of Claim/Proof of Loss

Delta Dental must be given written proof of loss within [12 months] [D133] after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within [12] [DJS134] months of the termination of this Contract.

#### 6.06 Time of Payment

Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Delta Dental will notify the Primary Enrollee and his/her Provider of any additional information needed to process the claim within this 30day period.

#### 6.07 Claims Appeal



Delta Dental's commitment to the Enrollee is to ensure quality throughout the entire dental benefit process: from the courtesy extended to the Enrollee by our Customer Service Representatives to the dental services provided by Premier and PPO Providers. If the Enrollee has questions about any services received, we recommend that the Enrollee first discusses the matter with his/her Provider. However, if the Enrollee continues to have concerns, they should call our Customer Service Center. The Enrollee can also e-mail questions by accessing the "Contact Us" section of our web site at [www.deltadentalins.com](http://www.deltadentalins.com).

Complaints or Appeals regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 800-521-2651.

When the Enrollee writes, he/she should include the name of the Enrollee, the Primary Enrollee's name and ID number, and their telephone number on all correspondence. The Enrollee should also include a copy of the claim form, claim statement, or other relevant information. The claim statement will have an explanation of the claim review and any complaint or appeal process and time limits applicable to such process.

Delta Dental will notify the Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee and his/her Provider have at least 180 days after receiving a notice of denial to request a review by writing to Delta Dental giving reasons why they believe the denial was wrong. The Enrollee and his/her Provider may also ask Delta Dental to examine any additional information provided that may support the complaint or appeal.

Send your complaint or appeal to Delta Dental at the address shown below:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023

Delta Dental will send the Enrollee a written acknowledgment within 5 days upon receipt of the [complaint] [grievance] or appeal. Delta Dental will make a full and fair review within 30 days after we receive the [complaint] [grievance] or appeal. Delta Dental may ask for more documents if needed. Delta Dental will send the Enrollee a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Delta Dental shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If the Enrollee believes he/she needs further review of their [complaint] [grievance] or appeal, he/she may [file a request with us for a second level review or] contact his/her state insurance regulatory agency.

#### **6.08 To Whom Benefits Are Paid**

Payment for services provided by a PPO Provider or a Premier Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Primary Enrollee. All Benefits not paid to the Provider will be payable to the Primary Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

### **ARTICLE 7 GENERAL PROVISIONS**

#### **7.01 Entire Contract; Changes**

This Contract, including the Application and the attachments listed in Article 9, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Delta Dental.

#### **7.02 Severability**

If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract will remain in full force and effect.

#### **7.03 Conformity With State Laws**

All legal questions about this Contract will be governed by the state of Arkansas where this Contract was entered into and is to be performed. Any part of this Contract which, on its Effective Date, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.

#### **7.04 Misstatements on Application; Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No

such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

**7.05 Legal Actions**

No action at law or in equity will be brought to recover on this Contract before 60 days after proof of loss has been filed in accordance with requirements of this Contract; nor will an action be brought after the expiration of three (3) years after the time written proof is required to be furnished.

**7.06 Not in Lieu of Workers' Compensation**

This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

**7.07 Certificate of Insurance**

[Delta Dental will issue to the Contractholder for delivery to each Primary Enrollee a certificate/Evidence of Coverage booklet summarizing the Benefits to which they are entitled and to whom Benefits are payable[D135].] [Delta Dental will issue to the Contractholder an electronic file containing a certificate/Evidence of Coverage booklet summarizing the Benefits to which Enrollees are entitled and to whom Benefits are payable. Each Primary Enrollee will have electronic access to the certificate[D136].] The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or riders showing the change will be issued.

**7.08 Publications About Program**

Contractholder and Delta Dental agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

**7.09 Professional Relationship**

Contractholder and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference.

**7.10 Notice; Where Directed**

All formal notice under this Contract must be in writing and sent by first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.

**[7.11 Indemnification[D137]**

Contractholder will indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Delta Dental will indemnify, defend and hold harmless Contractholder and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Agreement.]

**7.12 Time Limit On Certain Defenses**

After this Contract has been in force for three (3) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Enrollee with respect to the Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect three (3) years or more during his or her lifetime.

**7.13 Compliance with Administrative Simplification, Security and Privacy Regulations**

Contractholder shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information. The Contractholder agrees that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

**7.14 Impossibility of Performance**

Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

**7.15 Third Party Administrator (TPA)**

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate

Agreement with Delta Dental providing that the TPA shall meet HIPAA requirements for the preservation of protected health information of Enrollees.

**[7.16 Eligibility Update Through Delta Dental's Website][D138]**

Contractholder agrees to be responsible for any and all hardware, software or any other equipment, application or transmission capability to access the Delta Dental web site, including its Internet Access Provider (IAP) or Internet Service Provider (ISP). Contractholder will hold Delta Dental and its parent company, which provides computer processing services, harmless for any and all transmission or update delays, failures or errors caused by Contractholder's acts or omissions or caused by the ISP's acts or omissions. Contractholder agrees to hold Delta Dental and its parent company harmless for any and all potential breaches of confidentiality resulting from or arising out of the transmission or update of Enrollee eligibility information through Internet connections. Contractholder shall indemnify Delta Dental and its parent company from and against any liability or loss Delta Dental or its parent company may incur by reason of any covenant, condition or warranty contained in this Contract relating to confidentiality or the interception of transmission over the Internet by unknown third parties except for any breach caused by Delta Dental's or its parent company's error or omission.]

**ARTICLE 8  
TERMINATION AND RENEWAL,**

- 8.01 This Contract may be terminated only as follows:
- [By Contractholder upon [(60)] days written notice][d139].]
  - By Delta Dental,
    - (1) upon [(60)] days written notice if Contractholder fails to furnish Delta Dental a list of all Enrollees as required under section 2.01; or
    - (2) upon [(60)] days written notice if Contractholder fails to permit Delta Dental to inspect Contractholder's records as called for under section 2.02; or[d140]
    - (3) upon [(31)] [d141] days written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
  - By Delta Dental, if Contractholder reports fewer than the Minimum Number of Primary Enrollees shown in Appendix A for three (3) consecutive months. Delta Dental must give Contractholder notice within 15 days after receiving the list of Primary Employees which shows that Delta Dental may terminate on this basis.
  - By Delta Dental at the end of a Contract Term upon 60 days written notice.
- 8.02 In the event this Contract is terminated under Section 8.01 second bullet item, Contractholder will become immediately obligated upon termination to pay Delta Dental for that portion of the monthly Premium which constitutes for the current Contract Term Delta Dental's direct costs of administering this Contract (calculated by subtracting the pure Premium from the total Premium) multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25 percent of the total Premium for the entire Contract Term.
- 8.03 If Contractholder notifies Delta Dental that it intends to terminate this Contract upon less than 60 days notice, Section 8.02 will apply as if Delta Dental terminated this Contract under Section 8.01 second bullet.
- 8.04 Delta Dental will not be required to do Pre-treatment Estimates if this Contract is terminated for any cause nor will Delta Dental be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect.
- 8.05 Delta Dental will provide [(60)] [d142] days advance written renewal notice prior to the end of the initial or any subsequent Contract Term indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Delta Dental of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Delta Dental will terminate this Contract under 8.01 second bullet, item (3).

**ARTICLE 9  
ATTACHMENTS**

These documents are attached to this Contract and made a part of it:

**Appendix A      Group Policy Schedule**  
**Appendix B      Arkansas Life and Health Insurance Guaranty Association Act**  
**[Appendix C      Table of Allowances][D143]**  
**Copy of Application**  
**[Appendix to the Application][D144]**



**APPENDIX A**  
**GROUP POLICY SCHEDULE**  
*[Information in this section is variable.]*

**Contractholder Name:** [D145]

**Address:**

**Group Number:**

**Effective Date:**

**Contract Term:**

**Benefits** [d146] [d147]:

	<b>Contract Benefit Level</b>		
	<b><i>In-Network</i></b>	<b><i>Out-of-Network</i></b> [D148]	
	<b><i>PPO</i></b>	<b><i>Premier</i></b>	<b><i>Non-Delta Dental</i></b>
Diagnostic and Preventive Benefits:	%	%	%
[Basic Benefits:]	%	%	%
[Major Benefits:]	%	%	%
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%
[Implant Benefits:]	%	%	%
[Dental Accident Benefits:]	%	%	%

[Delta Dental will pay or otherwise discharge the Maximum Contract Allowance up to the amounts shown on the Table of Allowances, for Diagnostic and Preventive, Basic, Major, Implant and Dental Accident Benefits. However, Delta Dental will pay a percentage of the Maximum Contract Allowance for the following services: [d149]:

	<b>Contract Benefit Level</b>		
	<b><i>In-Network</i></b>	<b><i>Out-of-Network</i></b> [D150]	
	<b><i>PPO</i></b>	<b><i>Premier</i></b>	<b><i>Non-Delta Dental</i></b>
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%

**[Late Entrants:** Benefits for Late Entrants are limited until they have been enrolled in this Contract for [12] consecutive months [d151].]

	<b>Contract Benefit Level</b>		
	<b><i>In-Network</i></b>	<b><i>Out-of-Network</i></b> [D152]	
	<b><i>PPO</i></b>	<b><i>Premier</i></b>	<b><i>Non-Delta Dental</i></b>
Diagnostic and Preventive Benefits:	%	%	%
[Basic Benefits:]	%	%	%
[Major Benefits:]	%	%	%
[Orthodontic Benefits:]	%	%	%
[TMJ Benefits:]	%	%	%
[Implant Benefits:]	%	%	%
[Dental Accident Benefits:]	%	%	%

**Waiting Periods:** [D153]

- [[Basic Benefits [d154] are limited to Enrollees who have been enrolled in this Contract for [12[d155]] consecutive months.] [Waiting [d156] periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Basic Benefits [d157] are limited to Enrollees who have been enrolled in this Contract for [12[d158]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods [d159] are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Major Benefits [d160] are limited to Enrollees who have been enrolled in this Contract for [12[d161]] consecutive months.] [Waiting [d162] periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Major Benefits [d163] are limited to Enrollees who have been enrolled in this Contract for [12[d164]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods [d165] are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Orthodontic Benefits [d166] are limited to [dependent children of Primary Enrollees [d167]] [Primary Enrollees and their Dependent Enrollees] who have been enrolled in this Contract for [12[d168]] consecutive months.] [Waiting periods [d169] are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Orthodontic Benefits [d170] are limited to [dependent children of Primary Enrollees [d171]] [Primary Enrollees and their Dependent Enrollees] who have been enrolled in this Contract for [12] [d172] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods

[d173] are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]

- [[TMJ [d174] Benefits are limited to Enrollees who have been enrolled in this Contract for [12][d175] consecutive months.] [Waiting periods [d176] are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[TMJ Benefits [d177] are limited to Enrollees who have been enrolled in this Contract for [12][d178] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods [d179] are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]
- [[Implant Benefits [d180] are limited to Enrollees who have been enrolled in this Contract for [12][d181] consecutive months.] [Waiting periods [d182] are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]]  
[[Implant Benefits [d183] are limited to Enrollees who have been enrolled in this Contract for [12][d184] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods [d185] are calculated for each Primary Enrollee from the Effective Date reported by the Contractholder for said Primary Enrollee.]]

**Deductible Amount:**[d186]

For each Enrollee per [Contract/Calendar Year]: \$.[D187]  
For each family per [Contract/Calendar Year]: \$.[D188]  
[Lifetime Deductible per Enrollee[D189]: \$\_\_\_\_\_]

[Orthodontic Benefits are subject to a separate Deductible of \$ [per Enrollee/per dependent child Enrollee] per [Calendar/Contract Year/ lifetime[D190]]

[TMJ[D191] Benefits are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

[Implant Benefits [D192] are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

[The Deductible does not apply to Diagnostic and Preventive Services [or Orthodontic/TMJ/Implant Services[d193].]

[Any [D194] Deductible amount satisfied by the Enrollee during the last three (3) months of the year will be applied toward the Deductible for the following year.]

**[Deductible Takeover Credit:**

[Any Deductible satisfied by the Enrollees under the Contractholder's prior plan from January 1st to the Effective Date will be credited towards the Deductible under this Contract[d195].]

[Any Deductible satisfied by the Enrollees for [Orthodontic, TMJ or Implant Benefits] under the Contractholder's prior plan from January 1, 200\_\_to the Effective Date will be credited towards the Deductible under [this plan.][D196]

[Delta Dental will receive credit for any lifetime [Orthodontic, TMJ or Implant] Deductible amounts satisfied under the Contractholder's previous dental care plan[D197].]

**Maximum Amount:**[d198]

\$ \_\_\_\_\_ per Enrollee per [Contract/Calendar Year.[D199]].]  
\$ \_\_\_\_\_ per [[Enrollee/dependent child Enrollee] per [lifetime[d200]/Calendar/Contract Year] for Orthodontic Benefits.]  
\$ \_\_\_\_\_ [per Enrollee per lifetime for TMJ Benefits[D201].]  
\$ \_\_\_\_\_ [per Enrollee per lifetime for Implant Benefits[D202].]  
\$ \_\_\_\_\_ per Enrollee each [Contract/Calendar Year.[D203] For Dental Accident Benefits]

[The Maximum Amount does not apply to Diagnostic and Preventive Benefits.] [d204]

[Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care plan from January 1<sup>st</sup> to the Effective Date. These amounts will be credited towards the Calendar Year Maximum[D205].]

Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care Contract, if applicable, for [Orthodontic/TMJ/Implant Benefits]. These amounts will be credited towards the maximum amounts payable for [Orthodontic/TMJ/Implant Benefits[D206].]

**Termination:**

[Less than 10 Primary Enrollees[D207].]

[A [30%] reduction in the number of Primary Enrollees over three (3) consecutive months[D208].]

**Premiums:** [D209]

**Monthly Amount:**

[Per Primary Enrollee:	\$
Per Primary Enrollee and his/her Dependent Enrollees:]	\$
[Per Primary Enrollee:	\$
Per Primary Enrollee with one Dependent Enrollee:	\$
Per Primary Enrollee with two or more Dependent Enrollees:]	\$
[Per Primary Enrollee:	\$
Per Primary Enrollee and Spouse:	\$
Per Primary Enrollee and Child(ren):	\$
Per Primary Enrollee and Family:]	\$

***Premiums are to be remitted to:***

Delta Dental Insurance Company  
P. O. Box 1809  
Alpharetta, GA 30022-1809

**Payment Breakdown:**

Contractholder shall pay:	%	for Primary Enrollee
	%	for Dependent Enrollees
Primary Enrollee shall pay:	%	for Primary Enrollee
	%	for Dependent Enrollees

[Delta Dental [D210] shall receive a full month's Premium for all Enrollees.]

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

**APPENDIX B**  
**LIMITATIONS AND EXCLUSIONS UNDER THE**  
**ARKANSAS LIFE AND HEALTH INSURANCE**  
**GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverage’s, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state).
- The insurer was not authorized to do business in this state.
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to groups contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plan protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an allocated annuity contract now owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

## LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverage's. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage's. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**APPENDIX C [D211]**  
**Dentegra Insurance Company**  
**TABLE OF ALLOWANCES**

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Clinical Oral Evaluations</u></b>		
D0120	Periodic oral evaluation - established patient.....	26.00
D0140	Limited oral evaluation - problem focused .....	42.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	26.00
D0150	Comprehensive oral evaluation - new or established patient ( <i>limited to one per Provider, all other evaluations will be benefited as D0120</i> ).....	43.00
D0160	Detailed and extensive oral evaluation - problem focused, by report ( <i>limited to one per Provider all subsequent ones will be benefited as D0120</i> ) .....	56.00
D0180	Comprehensive periodontal evaluation - new or established patient ( <i>limited to one per Provider, all other evaluations will be benefited as D0120</i> ) .....	43.00
<b><u>Radiographs/Diagnostic Imaging</u></b> (Including Interpretation) ( <i>Any combination of bitewings, periapicals and panoramic films taken on the same day will be combined as a complete series when the fees are equal to or exceed that of a complete series</i> )		
D0210	Intraoral - complete series (including bitewings).....	78.00
D0220	Intraoral - periapical - first film.....	16.00
D0230	Intraoral - periapical - each additional film.....	12.00
D0240	Intraoral occlusal film .....	19.00
D0250	Extraoral - first film.....	19.00
D0260	Extraoral - each additional film.....	14.00
D0272	Bitewings - two films .....	25.00
D0273	Bitewings - three films .....	34.00
D0274	Bitewings - four films .....	43.00
D0277	Vertical bitewings - seven to eight films.....	53.00
D0330	Panoramic film .....	70.00
D0340	Cephalometric film ( <i>This is a benefit only in conjunction with orthodontic services</i> ).....	70.00
D0350	Oral/facial photographic images ( <i>This is a benefit only once per case in conjunction with orthodontic services</i> ) .....	42.00
<b><u>Test and Examinations</u></b>		
D0470	Diagnostic casts ( <i>This is a benefit only in conjunction with orthodontic services</i> ).....	54.00
<b><u>Dental Prophylaxis</u></b>		
D1110	Prophylaxis - adult .....	54.00
D1120	Prophylaxis - child ( <i>to age 14</i> ).....	43.00
<b><u>Topical Fluoride - (Office Procedure)</u></b>		
D1203	Topical Application of fluoride - child ( <i>through age 13</i> ) .....	22.00
D1204	Topical Application of fluoride - adult ( <i>subject to age limitation specified by the benefit plan</i> ).....	23.00
D1206	Topical fluoride varnish: therapeutic Application for moderate to high caries risk patients ( <i>subject to age limitation specified by the benefit plan</i> ) .....	23.00
<b><u>Other Preventive Services</u></b>		
D1351	Sealant - per tooth .....	28.00
	( <i>benefit to permanent first molars through age 8 and second molars through age 15</i> )	
<b><u>Space Maintainers (Passive Appliances)</u></b>		
D1510	Space maintainers – fixed, unilateral .....	202.00
D1515	Space maintainers – fixed, bilateral .....	310.00
D1520	Space maintainers – removable, unilateral.....	256.00
D1525	Space maintainers – removable, bilateral.....	287.00
D1555	Removal of fixed space maintainer .....	50.00
<b><u>Amalgam Restorations (Including Polishing)</u></b> ( <i>the fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp cap, local anesthesia, polishing, occlusal adjustment, caries, removal and gingivectomy on the same date of service. Replacement of restorations by the same Provider is a benefit after 24 months</i> )		
D2140	Amalgam - one surface, primary or permanent.....	59.00
D2150	Amalgam - two surfaces, primary or permanent .....	78.00
D2160	Amalgam - three surfaces, primary or permanent .....	93.00
D2161	Amalgam - four or more surfaces, primary or permanent.....	109.00
<b><u>Resin-Based Composite Restorations-Direct</u></b>		
D2330	Resin-based composite - one surface, anterior.....	71.00
D2331	Resin-based composite - two surface, anterior.....	87.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D2332	Resin-based composite - three surfaces, anterior .....	109.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).....	135.00
D2391	Resin-based composite - one surface, posterior .....	59.00
D2392	Resin-based composite - two surfaces, posterior .....	78.00
D2393	Resin-based composite - three surfaces, posterior .....	93.00
D2394	Resin-based composite - four or more surfaces, posterior .....	171.00

*Fees for Cast Restorations should include tooth preparation, pulp capping, laboratory costs, temporary restorations, porcelain margins, cement bases, routine buildup/substructure, impressions, local anesthesia, occlusal correction, preparation of the gingival tissue and any recementation or repair within six months.*

#### **Inlay/Onlay Restorations**

D2510	Inlay - metallic - one surface .....	233.00
D2520	Inlay - metallic - two surfaces .....	271.00
D2530	Inlay - metallic - three or more surfaces.....	305.00
D2542	Onlay - metallic - two surfaces.....	353.00
D2543	Onlay - metallic - three surfaces.....	377.00
D2544	Onlay - metallic - four or more surfaces .....	394.00
D2610	Inlay - porcelain/ceramic - one surface .....	233.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	271.00
D2630	Inlay - porcelain/ceramic - three or more surfaces .....	305.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	353.00
D2643	Onlay - porcelain/ceramic - three surfaces .....	377.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.....	394.00

#### **Crowns-Single Restorations Only**

D2740	Crown - porcelain/ceramic substrate .....	375.00
D2750	Crown - porcelain fused to high noble metal .....	383.00
D2751	Crown - porcelain fused to predominantly base metal .....	341.00
D2752	Crown - porcelain fused to noble metal .....	357.00
D2780	Crown - cast 3/4 high noble metal .....	395.00
D2781	Crown - cast 3/4 predominantly base metal .....	372.00
D2782	Crown - cast 3/4 noble metal.....	386.00
D2783	Crown - cast 3/4 porcelain/ceramic.....	405.00
D2790	Crown - full cast high noble metal .....	372.00
D2791	Crown - full cast predominantly base metal .....	330.00
D2792	Crown - full cast noble metal .....	349.00
D2794	Crown - titanium .....	372.00

#### **Other Restorative Services**

D2910	Recement inlay, onlay, or partial coverage restoration .....	28.00
D2915	Recement cast or prefabricated post and core .....	28.00
D2920	Recement crown.....	28.00
D2930	Prefabricated stainless steel crown - primary tooth.....	136.00
D2931	Prefabricated stainless steel crown - permanent tooth .....	98.00
D2932	Prefabricated resin crown.....	98.00
D2933	Prefabricated stainless steel crown with resin window .....	B/R*
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth .....	B/R*
D2940	Sedative Filling .....	50.00
D2950	Core build-up, including any pins ( <i>considered part of crown fee except in exceptional circumstances or for endodontically treated teeth</i> ).....	78.00
D2951	Pin retention - per tooth, in addition to restoration .....	28.00
D2952	Post and core in addition to crown, indirectly fabricated.....	116.00
D2954	Prefabricated post and core in addition to crown .....	98.00
D2960	Labial veneer (resin laminate) - chairside .....	147.00
D2961	Labial veneer (resin laminate) - laboratory .....	233.00
D2962	Labial veneer (porcelain laminate) - laboratory .....	299.00
D2971	Additional procedures to construct new crown under existing partial denture framework.....	B/R*
D2980	Crown repair.....	B/R*

#### **Pulpotomy**

D3220	Therapeutic pulpotomy (excluding final restoration).....	81.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .....	81.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Endodontic Therapy</u></b> (Including treatment plan, clinical procedures and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration) .....	350.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration) .....	415.00
D3330	Endodontic therapy, molar (excluding final restoration) .....	527.00
<b><u>Endodontic Retreatment</u></b>		
<i>Retreatment of root canal therapy within 24 months of the initial procedure is included in the original contracted fee when performed by the same Provider or in the original submitted fee when performed by an out-of-network Provider.</i>		
D3346	Retreatment of previous root canal therapy - anterior.....	419.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	496.00
D3348	Retreatment of previous root canal therapy - molar.....	605.00
<b><u>Apexification/Recalcification Procedures</u></b>		
D3351	Apexification/recalcification - initial visit.....	225.00
D3352	Apexification/recalcification - interim medication replacement .....	98.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy) .....	332.00
<b><u>Apicoectomy/Periradicular Services</u></b>		
D3410	Apicoectomy/periradicular surgery - anterior .....	273.00
D3421	Apicoectomy/periradicular surgery - bicuspid - (first root) .....	341.00
D3425	Apicoectomy/periradicular surgery - molar - (first root) .....	400.00
D3426	Apicoectomy/periradicular surgery - (each additional root) .....	124.00
D3430	Retrograde filling - per root .....	81.00
D3450	Root amputation - per root .....	186.00
<b><u>Other Endodontic Procedures</u></b>		
D3920	Hemisection (including any root removal), not including root canal therapy .....	186.00
<b><u>Surgical Services (Including usual postoperative care)</u></b>		
<i>On periodontal surgical procedures, the surgery is considered to include any surgical re-entry or scaling and root planing for three years.</i>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.....	245.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.....	87.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.....	310.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.....	186.00
D4249	Clinical crown lengthening - hard tissue.....	B/R*
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.....	451.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	270.00
D4270	Pedicle soft tissue graft procedure (limited to two sites per quadrant) .....	341.00
D4271	Free soft tissue graft procedure (including donor site surgery) (limited to two sites per quadrant) .....	391.00
<b><u>Non-Surgical Periodontal Service</u></b>		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	124.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant .....	74.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis .....	54.00
<b><u>Other Periodontal Services</u></b>		
D4910	Periodontal maintenance procedure .....	68.00
<b><u>Complete Dentures</u></b> (Includes routine post delivery care and relining for the first six months after placement)		
D5110	Complete denture - maxillary.....	426.00
D5120	Complete denture - mandibular .....	426.00
D5130	Immediate denture - maxillary .....	465.00
D5140	Immediate denture - mandibular .....	465.00
<b><u>Partial Dentures</u></b> (Includes routine post delivery care for the first six months after placement)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) .....	295.00
D5212	Mandibular partial denture -resin base (including any conventional clasps, rests and teeth) .....	295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00



PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	378.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	378.00
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) .....	310.00
<b><u>Adjustment to Dentures</u></b>		
D5410	Adjust complete denture - maxillary .....	37.00
D5411	Adjust complete denture - mandibular .....	37.00
D5421	Adjust partial denture - maxillary .....	37.00
D5422	Adjust partial denture - mandibular .....	37.00
<b><u>Repairs to Complete Dentures</u></b>		
D5510	Repair broken complete denture base .....	81.00
D5520	Replace missing broken tooth - complete denture (each tooth) .....	74.00
<b><u>Repairs to Partial Dentures</u></b>		
D5610	Repair resin denture base .....	81.00
D5620	Repair cast framework .....	115.00
D5630	Repair or replace broken clasp .....	109.00
D5640	Replace broken teeth - per tooth .....	74.00
D5650	Add tooth to existing partial denture.....	96.00
D5660	Add clasp to existing partial denture.....	109.00
<b><u>Denture Rebase Procedures</u></b> (Any rebase includes relining and any adjustments for six months following placement. One rebase per arch is covered in a 24 month period)		
D5710	Rebase complete maxillary denture.....	248.00
D5711	Rebase complete mandibular denture.....	248.00
D5720	Rebase maxillary partial denture .....	223.00
D5721	Rebase mandibular partial denture .....	223.00
<b><u>Denture Reline Procedures</u></b>		
D5730	Reline complete maxillary denture (chairside).....	144.00
D5731	Reline complete mandibular denture (chairside).....	144.00
D5740	Reline maxillary partial denture (chairside) .....	136.00
D5741	Reline mandibular partial denture (chairside) .....	136.00
D5750	Reline complete maxillary denture (laboratory).....	217.00
D5751	Reline complete mandibular denture (laboratory).....	217.00
D5760	Reline maxillary partial denture (laboratory) .....	205.00
D5761	Reline mandibular partial denture (laboratory) .....	205.00
<b><u>Interim Prosthesis</u></b>		
D5820	Interim partial denture - maxillary .....	175.00
D5821	Interim partial denture - mandibular .....	175.00
<b><u>Other Removable Prosthetic Services</u></b>		
D5850	Tissue conditioning - maxillary.....	47.00
D5851	Tissue conditioning - mandibular.....	47.00
<b><u>Maxillofacial Prosthetics</u></b>		
D5900-5999: Maxillofacial prosthetic procedures are generally not benefits of Delta Dental programs. When covered, they follow the benefits required under state regulatory guidelines, and typically are limited to services provided to newborn, dependent children for medically diagnosed congenital defects, birth abnormalities.		
<b><u>Implant Services</u></b>		
<b><u>Pre-Surgical Services</u></b>		
D6190	Radiographic/surgical implant index.....	B/R*
<b><u>Surgical Services</u></b>		
D6010	Surgical placement of implant body: endosteal implant .....	0.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant..... (Delta Dental considers this procedure part of the transitional prosthesis which is not a covered benefit)	0.00

D6040	Surgical placement: eposteal implant.....	0.00
D6050	Surgical placement: transosteal implant.....	0.00
PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Implant Supported Prosthetics</u></b>		
<b><u>Supporting Structures</u></b>		
D6055	Dental implant supported connecting bar.....	0.00
D5212	Mandibular abutment — includes placement.....	0.00
D6056	Prefabricated abutment — includes placement .....	0.00
D6057	Custom abutment — includes placement .....	0.00
<b><u>Implant/Abutment Supported Removable Dentures</u></b>		
D6053	Implant/abutment supported removable denture for completely edentulous arch.....	0.00
D6054	Implant/abutment supported removable denture for partially edentulous arch .....	0.00
<b><u>Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)</u></b>		
D6078	Implant/abutment supported fixed denture for completely edentulous arch .....	0.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.....	0.00
<b><u>Single Crowns, Abutment Supported</u></b>		
D6058	Abutment supported porcelain/ceramic crown.....	0.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	0.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	0.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	0.00
D6062	Abutment supported cast metal crown (high noble metal).....	0.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	0.00
D6064	Abutment supported cast metal crown (noble metal).....	0.00
D6094	Abutment supported crown — (titanium).....	0.00
<b><u>Single Crowns, Implant Supported</u></b>		
D6065	Implant supported porcelain/ceramic crown .....	0.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).....	0.00
D6067	Implant supported metal crown (titanium, titanium alloy, noble metal) .....	0.00
<b><u>Fixed Partial Denture, Abutment Supported</u></b>		
D6068	Abutment supported retainer for porcelain/ceramic FPD .....	0.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	0.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).....	0.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	0.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).....	0.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal) .....	0.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).....	0.00
D6194	Abutment supported retainer crown for FPD — (titanium) .....	0.00
<b><u>Fixed Partial Denture, Implant Supported</u></b>		
D6075	Implant supported retainer for ceramic FPD .....	0.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) ..	0.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal).....	0.00
<b><u>Other Implant Services</u></b>		
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis .....	0.00
D6090	Repair implant supported prosthesis .....	B/R*
D6095	Repair implant abutment .....	B/R*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.....	0.00
	<i>(D6091 is a benefit only after the prosthodontic time limitation (usually 5 years) has elapsed since the implant attachment was placed)</i>	
D6092	Recent implant/abutment supported crown .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6093	Recent implant/abutment supported fixed partial denture .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6094	CDT coding places procedure D6094 immediately following D6064 .....	0.00
D6190	CDT coding places procedure D6190 immediately before D6010 .....	0.00
D6194	CDT coding places procedure D6194 immediately following D6074 .....	0.00
D6199	Unspecified implant procedure .....	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Fixed Partial Denture Pontics</u></b>		
D6205	Pontic - indirect resin based composite .....	332.00
D6210	Pontic - cast high noble metal .....	370.00
D6211	Pontic - cast predominantly base metal .....	332.00
D6212	Pontic - cast noble metal .....	357.00
D6214	Pontic - titanium .....	370.00
D6240	Pontic - porcelain fused to high noble metal .....	369.00
D6241	Pontic - porcelain fused to predominantly base metal .....	346.00
D6242	Pontic - porcelain fused to noble metal .....	353.00
<b><u>Fixed Partial Denture Retainers—Inlays/Onlays</u></b>		
D6545	Retainer - cast metal for resin bonded fixed prosthesis .....	155.00
D6600	Inlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6602 will be given</i> ) .....	260.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6603 will be given</i> ) .....	302.00
D6602	Inlay - cast high noble metal, two surfaces .....	260.00
D6603	Inlay - cast high noble metal, three or more surfaces .....	302.00
D6604	Inlay - cast predominately base metal, two surfaces .....	260.00
D6605	Inlay - cast predominately base metal, three or more surfaces .....	302.00
D6606	Inlay - cast noble metal, two surfaces .....	260.00
D6607	Inlay - cast noble metal, three or more surfaces .....	302.00
D6608	Onlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6610 will be given</i> ) .....	361.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6611 will be given</i> ) .....	388.00
D6610	Onlay - cast high noble metal, two surfaces .....	361.00
D6611	Onlay - cast high noble metal, three or more surfaces .....	388.00
D6612	Onlay - cast predominately base metal, two surfaces .....	361.00
D6613	Onlay - cast predominately base metal, three or more surfaces .....	388.00
D6614	Onlay - cast noble metal, two surfaces .....	361.00
D6615	Onlay - porcelain/ceramic, three or more surfaces .....	388.00
D6624	Inlay - titanium .....	302.00
D6634	Onlay - titanium .....	388.00
<b><u>Fixed Partial Denture Retainers—Crowns</u></b>		
D6710	Crown - indirect resin based composite .....	B/R*
D6750	Crown - porcelain fused to high noble metal .....	383.00
D6751	Crown - porcelain fused to predominantly base metal .....	341.00
D6752	Crown - porcelain fused to noble metal .....	357.00
D6780	Crown - 3/4 cast high noble metal .....	395.00
D6781	Crown - 3/4 cast predominantly base metal .....	372.00
D6782	Crown - 3/4 cast noble metal .....	386.00
D6783	Crown - 3/4 cast porcelain/ceramic ( <i>an alternate benefit of D6780 will be given</i> ) .....	405.00
D6790	Crown - full cast high noble metal .....	372.00
D6791	Crown - full cast predominantly base metal .....	330.00
D6792	Crown - full cast noble metal .....	349.00
D6794	Crown - titanium .....	378.00
<b><u>Other Fixed Partial Denture Services</u></b>		
D6930	Recement fixed partial denture .....	39.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated .....	124.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer .....	98.00
D6973	Core buildup for retainer, including any pins .....	96.00
D6980	Fixed partial denture repair .....	B/R*
<b><u>Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7140	Extraction, erupted tooth or exposed root (elevation &/or forceps removal) .....	62.00
<b><u>Surgical Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7210	Surgical removal of erupted tooth .....	118.00
D7220	Removal of impacted tooth - soft tissue .....	155.00
D7230	Removal of impacted tooth - partially bony .....	205.00
D7240	Removal of impacted tooth - completely bony .....	242.00
D7250	Surgical removal of residual tooth roots (cutting procedure) .....	118.00
<b><u>Other Surgical Procedures</u></b>		
D7280	Surgical access of an unerupted tooth .....	155.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	B/R*
D7285	Biopsy of oral tissue - hard (bone, teeth) .....	158.00
D7286	Biopsy of oral tissue - soft .....	118.00

D7290 Surgical repositioning of teeth ..... B/R\*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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**Alveoloplasty – Surgical Preparation of Ridge**

D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	121.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	73.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ( <i>usually in preparation for prosthesis</i> ).....	167.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	101.00

**Vestibuloplasty**

D7340	Vestibuloplasty - ridge extension - (secondary epithelialization) .....	161.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachments and management of hypertrophied and hyper plastic tissue) .....	326.00

**Surgical Excision of Soft Tissue Lesions**

D7410	Excision of benign lesion to 1.25 cm .....	B/R*
D7411	Excision of benign lesion diameter greater than 1.25 cm .....	B/R*
D7412	Excision of benign lesion complicated.....	B/R*
D7413	Excision of malignant lesion, up to 1.25 cm .....	B/R*
D7414	Excision of malignant lesion greater than 1.25 .....	B/R*
D7415	Excision of malignant lesion, complicated.....	B/R*

**Surgical Excision of Intra-Osseous Lesions**

D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm .....	B/R*
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.....	B/R*
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25 cm.....	B/R*
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7460	Removal of benign nonodontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7461	Removal of benign nonodontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7465	Destruction of lesion(s) by physical or chemical methods .....	B/R*

**Excision of Bone Tissue**

D7471	Removal of lateral exostosis (maxilla or mandible).....	524.00
D7472	Removal of torus palatinus.....	524.00
D7473	Removal of torus mandibularis .....	524.00

**Surgical Incision**

D7510	Incision and drainage of abscess - intraoral soft tissue .....	B/R*
D7520	Incision and drainage of abscess - extraoral soft tissue.....	B/R*
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue .....	B/R*
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system .....	B/R*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone .....	B/R*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body .....	B/R*

**Treatment of Fractures-Simple**

D7610	Maxilla - open reduction (teeth immobilized, if present).....	B/R*
D7620	Maxilla - closed reduction (teeth immobilized, if present) .....	B/R*
D7630	Mandible - open reduction (teeth immobilized, if present).....	B/R*
D7640	Mandible - closed reduction (teeth immobilized, if present).....	B/R*
D7650	Malar and/or zygomatic arch - open reduction .....	B/R*
D7660	Malar and/or zygomatic arch - closed reduction. ....	B/R*
D7670	Alveolus - closed reduction, may include stabilization of teeth.....	B/R*
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches .....	B/R*

**Repair of Traumatic Wounds**

D7910	Suture - up to 5cm ( <i>when performed in conjunction with extractions, this service is considered to be included as part of the extraction</i> ) .....	B/R*
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**Complicated Suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)**

D7911	Complicated suture - up to 5 cm .....	B/R*
D7912	Complicated suture - greater than 5 cm.....	B/R*

**Other Repair Procedures**

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	B/R*
D7970	Excision of hyperplastic tissue - per arch.....	B/R*
D7971	Excision of pericoronal gingiva .....	B/R*

**PROCEDURE  
NUMBER**

**PROCEDURE DESCRIPTION**

**TABLE OF  
ALLOWANCE**

**Orthodontics**

*(Delta Dental's allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). Delta Dental will make an allowance for the cost of a standard orthodontic treatment when specialized orthodontic appliances or procedures are chosen for aesthetic considerations)*

**Delta Dental Limited Orthodontic Treatment**

D8010	Limited orthodontic treatment of the primary dentition.....	0.00
D8020	Limited orthodontic treatment of the transitional dentition.....	0.00
D8030	Limited orthodontic treatment of the adolescent dentition.....	0.00
D8040	Limited orthodontic treatment of the adult dentition.....	0.00

**Interceptive Orthodontic Treatment**

D8050	Interceptive orthodontic treatment of the primary dentition .....	0.00
D8060	Interceptive orthodontic treatment of the transitional dentition .....	0.00

**Comprehensive Orthodontic Treatment**

D8070	Comprehensive orthodontic treatment of the transitional dentition .....	0.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition .....	0.00
D8090	Comprehensive orthodontic treatment of the adult dentition .....	0.00

**Minor Treatment to Control Harmful Habits**

D8210	Removable appliance therapy .....	0.00
	<i>(This procedure is an orthodontic service only, and is not equivalent to a night guard, occlusal orthotic device, bite guard or occlusal splint which are provided for non-orthodontic purposes)</i>	
D8220	Fixed appliance therapy .....	0.00

**Other Orthodontic Services**

D8660	Pre-orthodontic treatment visit.....	0.00
	<i>(Equivalent to procedure D0150)</i>	
D8670	Periodic orthodontic treatment visit (as part of contract).....	0.00
	<i>(Delta Dental considers periodic treatment visits to be part of, and included in the contracted fees for, limited, interceptive and comprehensive orthodontic treatment)</i>	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s]) .....	0.00
D8690	Orthodontic treatment (alternative billing to a contract fee) .....	0.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers.....	0.00
D8999	Unspecified orthodontic procedure .....	B/R*

**Adjunctive General Services**

D9110	Palliative (emergency) treatment of dental pain - minor procedures .....	50.00
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**Anesthesia**

D9220	Deep sedation/general anesthesia - first 30 minutes.....	143.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.....	31.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.....	157.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes .....	29.00

**Professional Consultation** *(Delta Dental considers this procedure to be for a consultation by a specialist whose opinion or advice has been requested regarding a specific problem when routine diagnostic procedures have been performed by a general dentist and the treatment is not provided by the specialist).*

D9310	Consultation - diagnostic service provided by Provider or physician other than requesting Provider or physician .....	54.00
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**Miscellaneous Services**

D9930	Treatment of complications (post-surgical) - unusual circumstances .....	B/R*
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\*By Report – Delta Dental will determine the maximum allowance based on a narrative report submitted by the Provider.

**NOTE: The procedures described and allowances indicated on this table are subject to the terms of the Contract and Delta Dental processing policies and may be limited or excluded.**

Note: The above codes and nomenclature are copyright of the American Dental Association. Notes in italic type have been added by Delta Dental for clarification of its processing policies with respect to these procedures and are not part of the ADA's nomenclature.

Variable Information with Comments

Main document changes and comments		
<b>Page 1: Comment [D1]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
The Contractholder's name is entered as it appears on the Application.		
<b>Page 1: Comment [D2]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is to issue an electronic file to Contractholder; however, if printed certificates are negotiated, this sentence would be used and sentence associated with D3 would be deleted.		
<b>Page 1: Comment [D3]</b>	<b>delta</b>	<b>6/17/2009 11:20:00 AM</b>
Delta Dental's standard option; however, if the Contractholder negotiates printed certificates, this sentence is deleted and sentence associated with comment D2 is used.		
<b>Page 1: Comment [d4]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard Contract Year is 12 months but it would be changed to match what the client requested on Application provided Underwriting approves.		
<b>Page 1: Comment [D5]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
This sentence is used when the Application indicates that Benefits accumulate on a Contract Year basis.		
<b>Page 1: Comment [D6]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if domestic partners are to be covered; otherwise, delete.		
<b>Page 1: Comment [d7]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Employee will be the standard; however, reference will be changed to "Member" if the Contract is sold to other than an employer group. This change would be made throughout this document.		
<b>Page 1: Comment [D8]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use "Member" for association Contracts; change "Employee" to "Member" throughout Contract where applicable. Include "retiree" if retirees are to be covered; delete if retirees are not covered.		
<b>Page 1: Comment [d9]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use when PPO/PPO		
<b>Page 1: Comment [d10]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use when PPO/Program Allowance		
<b>Page 1: Comment [d11]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use when Table of Allowances.		
<b>Page 1: Comment [D12]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Delete if plan sold is not Table of Allowance.		
<b>Page 1: Comment [D13]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use this option when Contractholder submits eligibility with hardcopy enrollment forms or electronically (tape/Excel).		
<b>Page 1: Comment [d14]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
10 <sup>th</sup> is standard but may be adjusted based on Contractholder specifications.		
<b>Page 1: Comment [d15]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use this option when the Contractholder submits eligibility through the web site.		
<b>Page 1: Comment [D16]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
This wording is variable and will be customized for each Contractholder based on information provided in Application under plan requirements and/or special requests.		
<b>Page 1: Comment [D17]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if domestic partners are to be covered. If same sex partners are to be covered change references from "Domestic" to "Same Sex" throughout; otherwise, delete.		
<b>Page 1: Comment [DJS18]</b>	<b>Debbie</b>	<b>6/17/2009 11:51:00 AM</b>
Variable depending on Contractholder and/or state regulation.		

<b>Page 1: Comment [D19]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if children of domestic partners are to be covered; otherwise, delete.		
<b>Page 1: Comment [D20]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Underwriting approves delayed enrollment of children to beginning of Contract or Calendar year after a child turns age 4. The age may change as negotiated and approved by Underwriting. Must be section 125 and employees pay all of dependent premium. Choose Contract or Calendar Year as indicated on approved application.		
<b>Page 1: Comment [D21]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Contract/Calendar Year is chosen based on the Application.		
<b>Page 1: Comment [D22]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Contract/Calendar Year is chosen based on the Application.		
<b>Page 1: Comment [D23]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Variable. Keep this sentence if Contractholder will pay 100% of premiums for employee and/or dependent. If employee has to contribute for both/either, delete.		
<b>Page 1: Comment [D24]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Contractholder is contributing 100% of premiums for dependents; otherwise, delete.		
<b>Page 1: Comment [D25]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Contractholder is contributing 100% of premiums for dependents; otherwise, delete.		
<b>Page 1: Comment [D26]</b>	<b>delta</b>	<b>5/28/2009 10:44:00 AM</b>
This option is Delta Dental's standard and is used if group does not have a section 125 plan. If Contractholder is contributing 100% toward Employees' cost of coverage or has a section 125 plan, this option is deleted.		
<b>Page 1: Comment [D27]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use this option if there is a 125 plan. Delete this option if there is not a section 125 plan or if the Contractholder is contributing 100% toward Employees' cost of coverage.		
<b>Page 1: Comment [D28]</b>	<b>dpcxr5</b>	<b>5/28/2009 10:44:00 AM</b>
This option is Delta Dental's standard and is used if group does not have Section 125 plan. If Contractholder is contributing 100% toward Dependents' cost of coverage or has a Section 125 plan, this option is deleted.		
<b>Page 1: Comment [D29]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
This option is used if there is a 125 plan. Delete this option if there is not a section 125 plan or if the Contractholder is contributing 100% toward Dependents' cost of coverage.		
<b>Page 1: Comment [D30]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Choose Contract or Calendar Year as appropriate.		
<b>Page 1: Comment [D31]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Choose Contract or Calendar Year as appropriate.		
<b>Page 1: Comment [D32]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
this option is used if there is a 125 plan and Underwriting approves delayed enrollment of children to beginning of Contract or Calendar Year after child turns age 4. The age may change as negotiated and approved by Underwriting.		
<b>Page 1: Comment [D33]</b>	<b>dpcxr5</b>	<b>5/28/2009 10:44:00 AM</b>
Delta Dental's standard where one spouse may be covered as Primary Enrollee and also as a dependent of other if both are employees; children may only enroll under one parent.		
<b>Page 1: Comment [D34]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Option where one spouse may be covered as a Primary Enrollee and also as a dependent of other if both are employees; children may be covered under one or both parents.		
<b>Page 1: Comment [D35]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>



Option where one spouse may not be covered as a dependent of other if both are employees; children may be enrolled under only one parent.

<b>Page 1: Comment [D36]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Option where one spouse may not be covered as a dependent of other if both are employees; children may be enrolled as dependents under one or both parents.

<b>Page 1: Comment [D37]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Use wording in brackets only if approved by Underwriting.

<b>Page 1: Comment [d38]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Include if Contractholder selects this provision. 31 days is standard but different time frames may be used at the Contractholder's request.

<b>Page 1: Comment [D39]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Insert bracketed item if client requests that employees on approved leave of absence be allowed to continue coverage.

<b>Page 1: Comment [D40]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Choose Contract or Calendar Year as appropriate.

<b>Page 1: Comment [D41]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Choose Contract or Calendar Year as appropriate.

<b>Page 1: Comment [D42]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Use if coverage is effective first day of month.

<b>Page 1: Comment [D43]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Use if coverage is based on date of hire.

<b>Page 1: Comment [D44]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Choose Contract or Calendar Year as appropriate.

<b>Page 1: Comment [d45]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Would be used for employer/employee groups and deleted if sold to an association.

<b>Page 1: Comment [d46]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Standard is "of employment" for employer groups. Other wording would be used if sold to an association group.

<b>Page 1: Comment [D47]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Use if coverage terminates end of month.

<b>Page 1: Comment [d48]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Standard is "of employment" for employer groups. Other wording would be used if sold to an association group.

<b>Page 1: Comment [D49]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Use if coverage terminates date employment ends.

<b>Page 1: Comment [d50]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Would be included in all employer groups and deleted if sold to an association.

<b>Page 1: Comment [d51]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
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Would be included in all employer groups and deleted if sold to an association.

<b>Page 1: Comment [D52]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Use this item if approved Application indicates Contractholder has dual coverage; otherwise, delete.

<b>Page 1: Comment [D53]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
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Use this item if the approved Application indicates dental coverage is tied to medical coverage; otherwise, delete.

<b>Page 1: Comment [DJS54]</b>	<b>Debbie</b>	<b>6/17/2009 3:22:00 PM</b>
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Use this item if the approved Application indicates the Flexible Dual Choice option; otherwise, delete.

<b>Page 1: Comment [D55]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
First paragraph is used if enrollees are to be added date of hire or day following completion of eligibility. Second paragraph is used if enrollees are to be termed date of hire or day following completion of eligibility. Use both paragraphs if approved Application indicates eligibility effective date as day following completion of eligibility period or date of hire.		
<b>Page 1: Comment [D56]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard premium paragraph.		
<b>Page 1: Comment [d57]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use if premiums are paid in arrears; otherwise, delete and use standard paragraph from comment 54.		
<b>Page 1: Comment [D58]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
May be increased to 180 days if approved by Underwriting.		
<b>Page 1: Comment [d59]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
May be increased to 180 days if approved by Underwriting.		
<b>Page 1: Comment [D60]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is for this item to stay; however, delete it if section 3.06 is deleted.		
<b>Page 1: Comment [D61]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is for this item to stay; however, modify statement if section 3.06 and/or 3.07 are deleted.		
<b>Page 1: Comment [D62]</b>	<b>delta</b>	<b>5/28/2009 10:44:00 AM</b>
This section is Delta Dental's standard; however, it could be changed or deleted at Contractholder's request with Underwriting approval.		
<b>Page 1: Comment [D63]</b>	<b>delta</b>	<b>5/28/2009 10:44:00 AM</b>
Fifteen percent is Delta Dental's standard; however, it could be changed at Contractholder's request with Underwriting approval.		
<b>Page 1: Comment [D64]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Variable - The Benefits, limitations and exclusions in this section are variable and would be included or deleted based on approved Application. Comments show common variable choices.		
<b>Page 1: Comment [d65]</b>	<b>dpcxr5</b>	<b>6/18/2009 3:24:00 PM</b>
Standard is to refer to Appendix A; however if the group purchases one of the incentive plans the coinsurance information would be added in Section 4.04 below accordingly. Please refer to comment D149.		
<b>Page 1: Comment [d66]</b>	<b>dpcxr5</b>	<b>6/18/2009 3:26:00 PM</b>
Standard is to include wording; however if the group purchases one of the incentive plans this wording would be replaced with the applicable coinsurance information for the incentive plan purchased. See comment D1490.		
<b>Page 1: Comment [D67]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is for Periodontics to be a Basic benefit. However, this would be changed to Periodontic or Major if it is other than Basic.		
<b>Page 1: Comment [D68]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use if sealants are covered under D&P rather than the standard basic. If covered as standard Basic this item would be deleted. Contractholder may remove.		
<b>Page 1: Comment [D69]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is Basic; but Contractholder may change or remove.		
<b>Page 1: Comment [D70]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is Basic; but Contractholder may change or remove.		
<b>Page 1: Comment [D71]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is Basic; but Contractholder may change or remove.		
<b>Page 1: Comment [D72]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>

Standard. If sealants are covered under D&P this item would be deleted. Contractholder may remove.

Page 1: Comment [D73]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Basic; but Contractholder may change or remove.

Page 1: Comment [D74]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Basic; but Contractholder may change or remove.

Page 1: Comment [D75]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Basic; but Contractholder may change or remove.

Page 1: Comment [D76]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Basic; but Contractholder may change or remove.

Page 1: Comment [D77]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Basic; but Contractholder may change or remove.

Page 1: Comment [D78]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Major; but Contractholder may change or remove.

Page 1: Comment [D79]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is Major; but Contractholder may change or remove. If Contractholder does not want to cover implants reference to implants would be removed.

Page 1: Comment [D80]	delta	5/28/2009 6:21:00 AM
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This optional benefit would be included if the Contractholder chose to purchase this coverage for its Enrollees.

Page 1: Comment [D81]	delta	5/28/2009 6:21:00 AM
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This optional benefit would be included if the Contractholder chose to purchase this coverage for its enrollees.

Page 1: Comment [D82]	delta	5/28/2009 6:21:00 AM
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Include if separate Implant Benefit is purchased

Page 1: Comment [d83]	dpcjr5	5/28/2009 6:21:00 AM
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This optional benefit would be included if the Contractholder chose to purchase this coverage for its enrollees.

Page 1: Comment [D84]	dpcxr5	5/28/2009 6:21:00 AM
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Standard is 12 months; however, option would also include on Calendar Year or Contract Year basis.

Page 1: Comment [d85]	dpcjr5	5/28/2009 6:21:00 AM
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If Contractholder wants composite restorations covered on posterior teeth use period. If keeping standard composite wording, use "or".

Page 1: Comment [D86]	delta	5/28/2009 6:21:00 AM
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Standard is to include composite wording here; however, some groups may request that the Contract cover composite restorations on posterior teeth.

Page 1: Comment [D87]	delta	5/28/2009 6:21:00 AM
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12 months is standard. May also be calendar year or other time periods requested by Contractholder.

Additional cleanings/exams may also be requested

Page 1: Comment [d88]	dpcwr5	5/28/2009 6:21:00 AM
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If periodontal is covered as other than Basic, change this sentence accordingly.

Page 1: Comment [d89]	dpcjr5	5/28/2009 6:21:00 AM
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Five years is standard; however 3 years is an option and other time periods may be requested by Contractholder.

Page 1: Comment [d90]	dpcwr5	5/28/2009 6:21:00 AM
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Once each 12 months for Enrollees 18 and older and twice each 12 months for Enrollees under 18 is standard; however, Calendar Year or other time periods may be requested by Contractholder. Contractholder may also request different number of x-rays.

<b>Page 1: Comment [D91]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is to cover fluoride to age 19; however, Contractholder may request it be limited another age or to cover all (delete limitation if all covered).		
<b>Page 1: Comment [D92]</b>	<b>delta</b>	<b>5/28/2009 10:44:00 AM</b>
14 is Delta Dental's standard but another age may be requested by Contractholder.		
<b>Page 1: Comment [D93]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use if sealants are covered under D&P rather than the standard basic. If sold as standard basic benefit this item would be deleted.		
<b>Page 1: Comment [D94]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Age and time limits for sealants may vary based on request by Contractholder. Contractholder may remove.		
<b>Page 1: Comment [D95]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use if sealants are covered under standard Basic. If sold as D&P this item would be deleted.		
<b>Page 1: Comment [d96]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Age and time limits for sealants may vary based on request by Contractholder. Contractholder may remove.		
<b>Page 1: Comment [D97]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Time limit for restorations may be changed based on Contractholder's request.		
<b>Page 1: Comment [DJS98]</b>	<b>Debbie</b>	<b>6/17/2009 12:05:00 PM</b>
Standard is to cover as Major; however Contractholder may request as Basic. Contractholder may remove.		
<b>Page 1: Comment [d99]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Endodontics covered under Basic. Move to "Limitations on Major Benefits" if Contractholder covered under Major. Contractholder may remove.		
<b>Page 1: Comment [d100]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Periodontics covered under Basic. Move to "Limitations on Major Benefits" if Contractholder covered under Major. Standard surgery limitation is 3 or 5 years but other time periods may be requested by Contractholder.		
<b>Page 1: Comment [D101]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard options for crown and inlay/onlay restoration time limits are 5 or 9 years; however, it may be changed based on Contractholder's request. Contractholder may remove.		
<b>Page 1: Comment [D102]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Delete if implants are not covered or covered as separate category. If deleted, reference to implants would be deleted from remainder of section.		
<b>Page 1: Comment [D103]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard options for prosthodontic time limits are 5 or 9 years; however, it may be changed based on Contractholder's request		
<b>Page 1: Comment [DJS104]</b>	<b>Debbie</b>	<b>6/17/2009 12:06:00 PM</b>
Include if implants are covered.		
<b>Page 1: Comment [DJS105]</b>	<b>Debbie</b>	<b>6/17/2009 12:08:00 PM</b>
Include if implants are covered.		
<b>Page 1: Comment [d106]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this exclusion if missing teeth are not covered. Delete this exclusion if missing teeth are covered.		
<b>Page 1: Comment [D107]</b>	<b>dpcxr5</b>	<b>5/28/2009 10:44:00 AM</b>

Option “under a Delta Dental program” is standard; however, “prior plan” wording is also used if replacing another group dental plan.

<b>Page 1: Comment [d108]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if implants are not covered.		
<b>Page 1: Comment [D109]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Orthodontic Benefits are purchased.		
<b>Page 1: Comment [d110]</b>	<b>dpdjr5</b>	<b>5/29/2009 3:00:00 PM</b>
Lifetime is standard; however, other options are available if selected by Contractholder including Calendar Year and Contract Year.		
<b>Page 1: Comment [d111]</b>	<b>dpdjr5</b>	<b>6/24/2009 4:23:00 PM</b>
Standard is two (2) payments – 50% at the banding date and 50% in 12 months. Other payment frequencies may be requested by the Contractholder.		
<b>Page 1: Comment [D112]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use if Ortho Benefit is covered for children only. Include full-time students if indicated on Application.		
<b>Page 1: Comment [D113]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if TMJ Benefits are purchased.		
<b>Page 1: Comment [D114]</b>	<b>delta</b>	<b>6/17/2009 12:28:00 PM</b>
Include if a separate Implant Benefit is purchased. 5 years is standard time frame; however, time limit may be changed based on Contractholder's request if approved by Underwriting.		
<b>Page 1: Comment [D115]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Accidental Dental Injury Benefits are purchased.		
<b>Page 1: Comment [D116]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if implants are covered.		
<b>Page 1: Comment [D117]</b>	<b>dpcxr5</b>	<b>5/28/2009 10:44:00 AM</b>
Include prior plan wording if we are replacing another group dental plan. Use any Delta Dental program wording if not replacing, which is standard.		
<b>Page 1: Comment [D118]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this exclusion if missing teeth are not covered. Delete this exclusion if missing teeth are covered.		
<b>Page 1: Comment [d119]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if implants are not covered.		
<b>Page 1: Comment [d120]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Table of Allowance program; otherwise, delete this item.		
<b>Page 1: Comment [D121]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover oral surgery, general anesthesia or IV sedation, palliative treatment or sealants; otherwise, delete. Changes would be made if Contractholder does not want to exclude all services.		
<b>Page 1: Comment [D122]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover endodontics; otherwise, delete.		
<b>Page 1: Comment [D123]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover periodontics; otherwise, delete.		
<b>Page 1: Comment [D124]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover restorative treatment; otherwise, delete		
<b>Page 1: Comment [D125]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover denture repairs; otherwise, delete.		
<b>Page 1: Comment [D126]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover crowns, and inlays/onlays otherwise, delete.		

<b>Page 1: Comment [D127]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Would be included if Contractholder did not want to cover prosthodontics; otherwise, delete.		
<b>Page 1: Comment [D128]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Choose correct option as indicated on the approved Application.		
<b>Page 1: Comment [D129]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Use if Application indicates Deductible is on a Contract or Calendar Year basis.		
<b>Page 1: Comment [D130]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use if Application indicates Deductible is based on lifetime of Enrollee.		
<b>Page 1: Comment [D131]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard COB		
<b>Page 1: Comment [D132]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Non-Duplication COB		
<b>Page 1: Comment [D133]</b>	<b>delta</b>	<b>7/10/2009 1:44:00 PM</b>
12 months is standard; however, group may request and Underwriting may approve a reduced time frame down to 90 days.		
<b>Page 1: Comment [DJS134]</b>	<b>Debbie</b>	<b>7/10/2009 1:44:00 PM</b>
12 months after Contract Term is standard unless UW approves different run-out period; however, a group could ask for and Underwriting approve a shorter run-out time down to 90 days		
<b>Page 1: Comment [D135]</b>	<b>dpcxr5</b>	<b>6/17/2009 3:41:00 PM</b>
Standard is to issue an electronic file to Contractholder; however, if the Contractholder negotiates printed certificates, this sentence is kept and sentence associated with D138 is deleted.		
<b>Page 1: Comment [D136]</b>	<b>dpcxr5</b>	<b>6/17/2009 3:41:00 PM</b>
Standard option; however, if printed certificates are negotiated delete this option and use option D137.		
<b>Page 1: Comment [d137]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
This section is a standard provision that may be removed at Contractholder's request.		
<b>Page 1: Comment [D138]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include this section when client submits eligibility using web management.		
<b>Page 1: Comment [d139]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard is to exclude. Include if requested by Contractholder.		
<b>Page 1: Comment [d140]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
60 days is standard but may change if requested by Contractholder and approved by Underwriting.		
<b>Page 1: Comment [d141]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
31 days is standard but may change if requested by Contractholder and approved by Underwriting.		
<b>Page 1: Comment [d142]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
60 days is standard but may change if requested by Contractholder and approved by Underwriting.		
<b>Page 1: Comment [D143]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Table of Allowance would be included if Table of Allowance is purchased.		
<b>Page 1: Comment [D144]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Appendix to the Application would be included if Underwriting provides it or approves a change to the Application.		
<b>Page 1: Comment [D145]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Information will be completed for Contractholder Name, address, group number, effective date and Contract Term, based on the approved Application.		
<b>Page 1: Comment [d146]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>

This option if program is PPO/PPO or PPO/Program Allowance; this is the standard. Delete if one of the other options is purchased.

Page 1: Comment [d147]

dpcxr5

7/13/2009 3:11:00 PM

Wording would be added to the bulleted items under Section 4.04 if one of the following Program options is purchased:

Standard Incentive Plan:

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>Contract Benefit Level</i>			
<i>In-Network</i>	<i>Out-of-Network</i>		
	<i>Premier</i>	<i>Non-Delta Dental</i>	
xx%	xx%	xx%	during the Enrollee's first year
xx%	xx%	xx%	during the Enrollee's second year
xx%	xx%	xx%	during the Enrollee's third year
xx%	xx%	xx%	during the Enrollee's fourth year of coverage and thereafter.

Benefits will increase each year if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will either remain at the attained level, drop to the next lowest level or drop to the base level; under no circumstances would it fall below a base benefit level. Percentages could be between 0 and 100% In and out of network benefits may vary but not any more than twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base level.]

Partial Benefit Incentive Plan for part-time employees:

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>Contract Benefit Level</i>			
<i>In-Network</i>	<i>Out-of-Network</i>		
	<i>Premier</i>	<i>Non-Delta Dental</i>	
xx%	xx%	xx%	during the Enrollee's first year
xx%	xx%	xx%	during the Enrollee's second year
xx%	xx%	xx%	during the Enrollee's third year
xx%	xx%	xx%	during the Enrollee's fourth year of coverage and thereafter.

Benefits will increase each year if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will wither remain at the attained level, drop to the next lowest level or drop to the base level; under no circumstances would it fall below a base benefit level. Percentages could be between 0 and 100% In and out of network benefits may vary but not any more than up to twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base level.]

Enrollee/Member Incentive Plan:

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>Contract Benefit Level</i>			
<i>In-Network</i>	<i>Out-of-Network</i>		
	<i>Premier</i>	<i>Non-DeltaDental</i>	
xx%	xx%	xx%	during the Primary Enrollee's first year
xx%	xx%	xx%	during the Primary Enrollee's second year
xx%	xx%	xx%	during the Primary Enrollee's third year
xx%	xx%	xx%	during the Primary Enrollee's fourth year of coverage and thereafter.

Benefits will increase on the anniversary of the Primary Enrollee's Effective Date of Coverage under this Contract. Percentages could be between 0 and 100% In and out of network benefits may



vary but not any more than twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base level.]

<b>Page 1: Comment [D148]</b>	<b>delta</b>	<b>7/13/2009 3:11:00 PM</b>
Benefits vary by group coinsurance %. Options are 0% to 100%. In and out of network benefits may vary but not any more than twenty-five percent (25%). May be sold as a high/low program where percentages would be different. Enrollee would only be covered under one option at any given year. Basic, Major, Ortho and TMJ and implants may be deleted if not included in plan design chosen by the client.		
<b>Page 1: Comment [d149]</b>	<b>dpcxr5</b>	<b>6/17/2009 1:02:00 PM</b>
Use this option if program is PPO with Table of Allowances.		
<b>Page 1: Comment [D150]</b>	<b>delta</b>	<b>7/13/2009 3:10:00 PM</b>
Benefits vary by group coinsurance %. Options are 0% to 100%. In and out of network benefits may vary but not any more than twenty-five percent (25%). May be sold as a high/low program where percentages would be different. Enrollee would only be covered under one option at any given year. Ortho and TMJ and implants may be deleted if not included in plan design chosen by the client.		
<b>Page 1: Comment [d151]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Contractholder selects a "Late Entrant Provision", otherwise delete; 2 months is standard but other time frames may be requested by Contractholder.		
<b>Page 1: Comment [D152]</b>	<b>delta</b>	<b>7/13/2009 3:11:00 PM</b>
Benefits vary by group coinsurance %. Options are 0% to 100%. In and out of network benefits may vary but not any more than twenty-five percent (25%). May be sold as a high/low program where percentages would be different. Enrollee would only be covered under one option at any given year. Basic, Major, Ortho and TMJ may be deleted if not included in plan design chosen by the Contractholder.		
<b>Page 1: Comment [D153]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if waiting periods apply; otherwise, delete.		
<b>Page 1: Comment [d154]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – dependent waiting period is determined by his/her own length of coverage.		
<b>Page 1: Comment [d155]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d156]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder client has prior coverage.		
<b>Page 1: Comment [d157]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage		
<b>Page 1: Comment [d158]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d159]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder has prior coverage.		
<b>Page 1: Comment [d160]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – dependent waiting period is determined by his/her own length of coverage.		
<b>Page 1: Comment [d161]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d162]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder client has prior coverage.		
<b>Page 1: Comment [d163]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage.		



<b>Page 1: Comment [d164]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d165]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder has prior coverage.		
<b>Page 1: Comment [d166]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – dependent waiting period is determined by his/her own length of coverage.		
<b>Page 1: Comment [d167]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use if only dependent children are covered under Orthodontic Benefits.		
<b>Page 1: Comment [d168]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d169]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder has prior coverage.		
<b>Page 1: Comment [d170]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage.		
<b>Page 1: Comment [d171]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Use if only dependent children are covered under Orthodontic Benefits.		
<b>Page 1: Comment [d172]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d173]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when client has prior coverage.		
<b>Page 1: Comment [d174]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – dependent waiting period is determined by his/her own length of coverage.		
<b>Page 1: Comment [d175]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d176]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder has prior coverage.		
<b>Page 1: Comment [d177]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage.		
<b>Page 1: Comment [d178]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d179]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when client has prior coverage.		
<b>Page 1: Comment [d180]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – dependent waiting period is determined by his/her own length of coverage.		
<b>Page 1: Comment [d181]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d182]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when client has prior coverage.		
<b>Page 1: Comment [d183]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage.		
<b>Page 1: Comment [d184]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Time period options for all waiting periods is 6 months to 36 months.		
<b>Page 1: Comment [d185]</b>	<b>dpcwr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include this sentence when Contractholder has prior coverage.		
<b>Page 1: Comment [d186]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>

Standard – deductible the same for both in- and out-of-network; program option available for different deductibles in- and out-of-network if allowed by state regulations and selected by Contractholder. If an Enrollee switches between the In-Network and Out-of-Network Benefits during a Calendar Year the Deductibles may be adjusted accordingly

<b>Page 1: Comment [D187]</b>	<b>delta</b>	<b>6/17/2009 12:28:00 PM</b>
Use this option for individual deductible. Choose Contract or Calendar Year per application. Range for individual deductible is \$0 - \$500. If no deductible applies, the variables would be deleted from the Deductible section. If sold as a high/low plan, there could be a separate deductible for each option.		
<b>Page 1: Comment [D188]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Will be taken from approved Application. Ranges are \$0-\$1500.		
<b>Page 1: Comment [D189]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if group has separate lifetime Ortho deductible. Ranges are \$0- \$500.		
<b>Page 1: Comment [D190]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Orthodontic Benefit has a separate Deductible. \$0-\$500 for calendar or Contract Year and \$0-\$500 for lifetime. Would be indicated in special request section of Application.		
<b>Page 1: Comment [D191]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if TMJ has a separate Deductible. \$0-\$500 for calendar or Contract Year and \$0-\$500 for lifetime. Would be indicated in special request section of Application.		
<b>Page 1: Comment [D192]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Implant Benefits have a separate Deductible. \$0-\$500 for calendar or Contract Year and \$0-\$500 for lifetime. Would be indicated in special request section of Application.		
<b>Page 1: Comment [d193]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Will be included if Deductible is waived and will also indicate what services it is waived on.		
<b>Page 1: Comment [D194]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if there is fourth quarter carryover. Would be indicated in special request section of Application.		
<b>Page 1: Comment [d195]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if there is Deductible takeover and replacing another group plan after January that is on a Calendar year basis		
<b>Page 1: Comment [D196]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if there is Deductible takeover and replacing another group plan after January that has separate calendar year Deductibles for one or more of these Benefits.		
<b>Page 1: Comment [D197]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if taking over another group plan that has separate lifetime Deductibles for one or more of these Benefits		
<b>Page 1: Comment [d198]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Standard – maximum the same for both in- and out-of-network; program option available for different maximums in- and out-of-network if allowed by state regulations and selected by Contractholder. The combined maximum amount payable each year for In-Network and Out-of-Network Benefits will not exceed the maximum amount for In-Network Benefits. However, if only Out-of-Network Benefits are used for the calendar year, the maximum will not exceed the Out-of Network maximum.		
<b>Page 1: Comment [D199]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Based on approved Application. Options are \$ 500 - \$5,000.		
<b>Page 1: Comment [d200]</b>	<b>dpdjr5</b>	<b>5/28/2009 6:21:00 AM</b>
Lifetime is standard but Contractholder may elect Contract Year or Calendar Year. \$500 - \$5,000.		
<b>Page 1: Comment [D201]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if separate TMJ benefit is sold; amount will be based on Application. \$500 - \$5,000 lifetime.		

<b>Page 1: Comment [D202]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if separate implant benefit is sold; amount will be based on Application. \$500 - \$5000 lifetime.		
<b>Page 1: Comment [D203]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Based on Application. Options are \$0-\$5,000.		
<b>Page 1: Comment [d204]</b>	<b>dpcjr5</b>	<b>6/18/2009 3:35:00 PM</b>
Would be used when Contractholder purchases the option where D&P Benefits do not apply towards the Enrollee's yearly maximum. Standard would be not to include this.		
<b>Page 1: Comment [D205]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Include if Application indicates maximum takeover on a calendar year group after January.		
<b>Page 1: Comment [D206]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include if taking over Orthodontic, TMJ or implant Benefits from prior carrier.		
<b>Page 1: Comment [D207]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
10 is standard but may go down to 5 with Underwriting approval.		
<b>Page 1: Comment [D208]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
Option that can be used when indicated to do so on Application. 30% is standard but variable with Underwriting approval.		
<b>Page 1: Comment [D209]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Standard variables – other variables available at the request of the Contractholder – per approved Application.		
<b>Page 1: Comment [D210]</b>	<b>delta</b>	<b>5/28/2009 6:21:00 AM</b>
Include this statement for small groups or other clients as deemed necessary by Underwriting when eligibility is DOH.		
<b>Page 1: Comment [D211]</b>	<b>dpcxr5</b>	<b>5/28/2009 6:21:00 AM</b>
This is a sample Table of Allowances. Procedures covered and maximum allowances will vary depending on the plan purchased by the Contractholder.		
<b>Header and footer changes</b>		
<b>Text Box changes</b>		
<b>Header and footer text box changes</b>		
<b>Footnote changes</b>		
<b>Endnote changes</b>		

**Contract Amendment**

**AMENDMENT NO:** [redacted] [d1]

**Group No.:** [redacted] [d2]

*Information on this form is variable*

**IT IS AGREED** that the Contract effective [redacted] [d3] between **DENTEGRA INSURANCE COMPANY** and [redacted] [d4] is hereby **AMENDED** effective [redacted] [d5] as follows:

[redacted] [d6]

Except as **AMENDED** all terms and provisions of this Contract shall remain unchanged.

[redacted] [d7]

---

Signature of Contractholder

**DENTEGRA INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read 'Anthony S. Barth', written over a horizontal line.

Anthony S. Barth, Vice Chairman

Main document changes and comments		
<b>Page 1: Comment [d1]</b>	<b>dpcxr5</b>	<b>4/1/2009 9:43:00 AM</b>
Add correct # based on previous amendments to the contract.		
<b>Page 1: Comment [d2]</b>	<b>dpcxr5</b>	<b>2/18/2009 8:02:00 AM</b>
Insert group number		
<b>Page 1: Comment [d3]</b>	<b>dpcxr5</b>	<b>2/18/2009 8:02:00 AM</b>
Insert effective date of the group contract		
<b>Page 1: Comment [d4]</b>	<b>dpcxr5</b>	<b>3/30/2009 4:27:00 PM</b>
Insert Contractholder's name		
<b>Page 1: Comment [d5]</b>	<b>dpcxr5</b>	<b>3/30/2009 4:27:00 PM</b>
Insert date the change/revision is effective		
<b>Page 1: Comment [d6]</b>	<b>dpcxr5</b>	<b>4/1/2009 9:43:00 AM</b>
Insert appropriate variable from the PPO Contract that addresses the change requested by the group and approved by Underwriting.		
<b>Page 1: Comment [d7]</b>	<b>dpcxr5</b>	<b>3/30/2009 4:27:00 PM</b>
Insert Contractholder's name		
Header and footer changes		
Text Box changes		
Header and footer text box changes		
Footnote changes		
Endnote changes		

## Evidence of Coverage Amendment

AMENDMENT NO: [REDACTED] [d1]

Group No.: [REDACTED] [d2]

*Information on this form is variable*

**IT IS AGREED** that the Contract effective [REDACTED] [d3] between **DENTEGRA INSURANCE COMPANY** and [REDACTED] [d4] is hereby **AMENDED** effective [REDACTED] [d5] as follows:

[REDACTED] [d6]

Except as **AMENDED** all terms and provisions of the Certificate shall remain unchanged.

**DENTEGRA INSURANCE COMPANY**

A handwritten signature in black ink, appearing to read 'Anthony S. Barth', written over a horizontal line.

Anthony S. Barth, Vice Chairman

E-AMEND

Main document changes and comments		
<b>Page 1: Comment [d1]</b> Add correct # based on previous amendments to the contract.	dpcxr5	2/18/2009 7:45:00 AM
<b>Page 1: Comment [d2]</b> Insert group number	dpcxr5	2/18/2009 7:45:00 AM
<b>Page 1: Comment [d3]</b> Insert effective date of the group contract	dpcxr5	2/18/2009 7:45:00 AM
<b>Page 1: Comment [d4]</b> Insert Group's/Contractholder's name	dpcxr5	2/18/2009 8:01:00 AM
<b>Page 1: Comment [d5]</b> insert date the change/revision is effective	dpcxr5	2/18/2009 7:46:00 AM
<b>Page 1: Comment [d6]</b> Insert appropriate variable from the PPO EOC that addresses the change requested by the group and approved by Underwriting.	dpcxr5	4/1/2009 1:51:00 PM
Header and footer changes		
Text Box changes		
Header and footer text box changes		
Footnote changes		
Endnote changes		



## APPENDIX TO THE GROUP APPLICATION

*Information on this page is variable*

Contract #: [d1]

For: [d2]

(Name of Group)

**IT IS AGREED** that the Application between **DENTEGRA INSURANCE COMPANY** and [d3] is hereby **AMENDED** as follows:

[d4]

Except as **AMENDED** all terms and provisions of the Group Application shall remain unchanged.

**DENTEGRA INSURANCE COMPANY**

**Add appropriate officer with signature**



Main document changes and comments		
Page 1: Comment [d1] Insert group number	dpcxr5	2/18/2009 8:39:00 AM
Page 1: Comment [d2] Insert Group's/Contractholder's name	dpcxr5	2/18/2009 8:39:00 AM
Page 1: Comment [d3] Insert Group's/Contractholder's name	dpcxr5	2/18/2009 8:39:00 AM
Page 1: Comment [d4] Insert corrected information here. This would include if the coinsurance, maximum, premiums, dependent ages, waiting periods, etc. were incorrectly indicated on the application or the group's name was incorrect.	dpcxr5	2/18/2009 8:39:00 AM
Header and footer changes		
Text Box changes		
Header and footer text box changes		
Footnote changes		
Endnote changes		

Underwritten by:



Administered by:



Delta Dental Insurance Company

GROUP NAME [D1]



[www.deltadentalins.com](http://www.deltadentalins.com)

Group No: [D2]

Effective Date: [D3]

Revised: [D4]

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## Attachments

[TABLE OF ALLOWANCES]

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

## INTRODUCTION

We are pleased to welcome you to the group dental plan for [group name]. Your plan is underwritten by Dentegra Insurance Company and administered by Delta Dental Insurance Company (collectively referred to as "Delta Dental"). Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

### Using This Evidence of Coverage

This Evidence of Coverage booklet discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

**Notice:** *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

### Contact Us

For more information please visit our web site at [www.deltadentalins.com](http://www.deltadentalins.com) or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 800-521-2651 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809



Anthony S. Barth, Vice Chairman

## GROUP HIGHLIGHTS

### Plan[D5]:

[You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.] [You have a Contract Year plan and deductibles and maximums will be based upon a Contract Year, which is the [12[D6]] months starting on the Effective Date and each subsequent 12 month period thereafter.]

### [Benefits: [D7]

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Diagnostic and Preventive Benefits:	%	%	%
Basic Benefits:	%	%	%
Major Benefits:	%	%	%
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%
Implant Benefits:	%	%	%
Dental Accident Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

### [Benefits[D8]:

We will pay the Maximum Contract Allowance up to the amounts shown on the Table of Allowances, which is attached at the end of this Evidence of Coverage, for Diagnostic & Preventive, Basic, Major, Implant and Dental Accident Benefits. However, Delta Dental will pay a percentage of the Maximum Contract Allowance for the following services:

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

### [Late Entrants:[D9]

Benefits for Late Entrants are limited until they have been enrolled in the Contract for [12] consecutive months. Please see the Late Entrants paragraph in the Eligibility and Enrollment section for more information.

	<b>Contract Benefit Level</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	
	<b>PPO</b>	<b>Premier</b>	<b>Non-Delta Dental</b>
Diagnostic and Preventive Benefits:	%	%	%
Basic Benefits:	%	%	%
Major Benefits:	%	%	%
Orthodontic Benefits:	%	%	%
Temporomandibular Joint Dysfunction (TMJ) Benefits:	%	%	%
Implant Benefits:	%	%	%
Dental Accident Benefits:	%	%	%

Percentages are based on the Maximum Contract Allowance.]

**[Waiting Periods:[D10]**

- **[[D11]**Basic, Major, TMJ, Implant and Dental Accident Benefits are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. [The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] **[D12]**[Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the effective date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]**[D13]**
- [Orthodontic Benefits are limited to [dependent children of Primary Enrollees]**[D14]** [Primary Enrollees and their Dependents**[D15]** who have been enrolled in the Contract for 12 consecutive months. [The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] **[D15]** [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the effective date reported by the Contractholder for said Primary Enrollee and/or Dependent Enrollee.]**[D17]**

**Deductible[d18]:**

- **[[D19]** For each Enrollee per [Contract/Calendar] Year is \$XX.]
- **[[D20]**For all family members per [Contract/Calendar] Year is \$XXX.]
- **[[D21]**The lifetime Deductible for each Enrollee is \$XXX.]
- **[[D22]**Orthodontic Benefits are subject to a separate Deductible of \$XXX [per Enrollee/per dependent child enrollee] per [Calendar/Contract Year/lifetime.]
- **[[D23]**TMJ Benefits are subject to a separate Deductible of \$XXX [per Enrollee/per dependent child enrollee] per [Calendar/Contract Year/lifetime.]
- Implant Benefits **[D24]**are subject to a separate Deductible of \$ per Enrollee per [Calendar/Contract Year/lifetime.]

**[[D25]**The Deductible does not apply to Diagnostic and Preventive Benefits or [Orthodontic/TMJ Benefits].]

**[[D26]**Any Deductible amount you satisfied during the last three (3) months of the year will be applied toward the Deductible for the following year.]

**[Takeover Credit: [D27]**Any Deductible you satisfied under the Contractholder's prior plan from January 1st to the Effective Date will be credited toward the Deductible under the Contract.]

**[Takeover Credit: [[D28]** Any Deductible you satisfied for [Orthodontic/TMJ] Benefits under the Contractholder's prior plan from January 1st to the Effective Date will be credited toward the Deductible under the Contract.] **[[D29]**Any lifetime Deductible you satisfied for [Orthodontic/TMJ] Benefits under the Contractholder's prior plan will be credited toward the lifetime Deductible under the Contract.]]

**Maximum[d30]:**

- **[[D31]**The maximum payable each [Contract/Calendar] Year for Benefits is \$XXX per Enrollee/Family.]
- **[[D32]**The maximum [lifetime/Calendar Year/Contract Year] amount per [dependent child] Enrollee for Orthodontic Benefits is \$XXX.]
- **[[D33]**A separate maximum amount payable [Contract/Calendar] Year for TMJ Benefits is \$XX per Enrollee.]
- **[[D34]**The lifetime maximum amount per Enrollee for Implant Benefits is \$XXX.]
- **[[D35]**The maximum payable each [Contract/Calendar] Year for Dental Accident Benefits is \$ XXX per Enrollee.]
- [The Maximum Amount does not apply to Diagnostic and Preventive Benefits.]**[d36]**

**[Maximum Takeover Credit: [D37]**

We will receive credit for any amounts paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited toward the Calendar Year Maximum.]

**[Lifetime Orthodontic/TMJ Takeover Credit:[D38]]**

We will receive credit for any amounts paid under the Contractholder's previous dental care contract, if applicable, for [Orthodontic/TMJ Benefits]. These amounts will be credited toward the maximum amounts payable for [Orthodontic/TMJ Benefits.]

[[D39]The Maximum Amount does not apply to Diagnostic and Preventive Services.]

**Premiums[D40]:**

You are [not] required to contribute towards the cost of your coverage.

You are [not] required to contribute towards the cost of your Dependent's coverage.

We may cancel the Contract [31] days after written notice to the Contractholder if monthly premiums are not paid when due.

**DEFINITIONS**

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network):** the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a PPO Provider. Out-of-Network Benefits are those covered by the Contract but performed by a Premier Provider or a Non-Delta Dental Provider..

**Claim Form:** the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

**Contract:** the written agreement between Delta Dental and the Contractholder under which Benefits are provided.

**Contract Benefit Level:** percentage of Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied.

**Contractholder:** the employer, union or other organization or group contracting to obtain Benefits.

**Deductible:** a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

**Delta Dental** – means collectively, Dentegra Insurance Company and Delta Dental Insurance Company providing and/or administering dental benefit programs. For the purposes of this Contract, Dentegra Insurance Company is the underwriter and Delta Dental Insurance Company is the administrator.

**Delta Dental Premier® Provider (Premier Provider)** – a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under a plan and complies with Delta Dental's administrative guidelines.

**Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee)** – the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating Enrollees.

**Delta Dental PPO<sup>SM</sup> Provider (PPO Provider)** -- a Provider who contracts with Delta Dental Insurance Company or any other member company of the Delta Dental Plans Association and agrees to accept the contracted fees as payment in full for services provided under this PPO dental plan and complies with Delta Dental's administrative guidelines.

**Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee)** -- the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating Enrollees.

**Dependent Enrollee:** an Eligible Dependent enrolled to receive Benefits.

**Effective Date:** the date the program starts. This date is given on this booklet cover.

**Eligible Dependent:** a dependent of an Eligible Employee [or domestic partner ] [D41] eligible for Benefits.

**Eligible [Employee/Member ]:** [D42] any [employee/member/or retiree [D43]] as eligible for Benefits.

**Enrollee:** an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".

**Enrollee's Effective Date of Coverage:** the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

**[Late Entrant:** an Eligible [Employee/Member] or and/or Eligible Dependent who does not enroll for coverage under the Contract within [31] days of the date first eligible, but later becomes covered; or who requests coverage after previously terminating coverage while still eligible for coverage under the Contract.][D44]

**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [D45] by PPO Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee for a PPO Provider's in the same geographic area.]
- [D46] by PPO Providers is the lesser of the Submitted Fee on the claim or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim or the Premier Provider's Contracted Fee; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the Program Allowance.]
- [D47] by PPO Providers is the lesser of the Submitted Fee on the claim, the amount shown on the Table of Allowances, or the PPO Provider's Contracted Fee; or
- by Premier Providers is the lesser of the Submitted Fee on the claim, the amount shown on the Table of Allowances, or the Premier Provider's Contracted Fee; or
- by Non-Delta Dental Providers is the lesser of the Submitted Fee on the claim or the amount shown on the Table of Allowances.]

**Non-Delta Dental Provider:** a Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines and has not agreed to accept the contracted fees.

**Open Enrollment Period:** the month of the year during which employees may change coverage for the next Contract Year.

**Patient Pays:** Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.



**Primary Enrollee:** an Eligible Employee enrolled in the plan to receive Benefits.

**Procedure Code:** the Current Dental Terminology® (CDT) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by us for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualifying Status Change:** a change in:

- legal marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee, spouse or dependent child);
- dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by IRC Section 125.

**Single Procedure:** a dental procedure that is assigned a separate CDT® number.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

**[Table of Allowances][D48]:** the list of covered dental services showing the Procedure Code and the maximum amount paid by Delta Dental for each covered Single Procedure. The Table of Allowances is attached at the end of this Evidence of Coverage.]

## ELIGIBILITY AND ENROLLMENT

### Eligibility Requirements

You will become eligible to receive benefits on the date stated in the Contract after completing any eligibility periods required by the Contract or as stated in the Contract.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Lawful spouse [or domestic partner named in the Contractholder's Affidavit of Domestic Partnership][D49];
- Unmarried dependent children from birth to [the end of the month of][d50] their 19th birthday or 25th birthday, if a full-time student in an accredited school. Proof of full-time student status must be given to Delta Dental within 60 days when requested. "Children" includes natural children, step-children, adopted children, [children of your domestic partner,][D51] foster children and children for which the employee has been appointed legal guardian. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. [D52] However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any [Contract/Calendar] Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the [Contract/Calendar] Year immediately following said child's fourth birthday.]
- An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is

mostly dependent on the Primary Enrollee for support and maintenance. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

## Enrollment Requirements

[If the [d53] Contractholder is paying all premiums for you [and your dependents, everyone is [D54]] [, you are [D55]] automatically enrolled.]

[[D56]]If you are paying all or a portion of premiums for yourself or your dependents then:]

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees [who are not covered under another group dental plan] [D57] for coverage.
- [[D58]]You must pay Premiums in the manner elected by the Contractholder and approved by us. If coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, you may not re-enroll except during an Open Enrollment Period.]  
[[D59]]You must pay Premiums in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.]
- [[D60]]If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. If coverage is dropped other than during an Open Enrollment Period, your dependents may not be re-enrolled at any time unless there is a court order requiring dependent coverage.]  
[[D61]]If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]  
[[D62]]If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us. Dependent Enrollees must be enrolled within 31 days after the date becoming eligible or during the Open Enrollment Period. However, the eligibility date for young children, under the age of four (4), may be delayed until the beginning of any [[Contract/Calendar] Year including the [Contract/Calendar] Year immediately following the child's fourth birthday. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.]
- [[D63]]If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[[D64]]If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]  
[[D65]]If both you and your spouse are eligible persons, one of you may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.]  
[[D66]]If both you and your spouse are eligible persons, one of you may not enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of one or both Primary Enrollees.]
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

[Late Entrant] [D67]

[You and/or your dependents will be considered a Late Entrant if:

- You and/or your Eligible Dependents do not enroll for coverage under the Contract within [31] days of the date first eligible, but later become covered; or
- You request coverage for yourself and/or your Eligible Dependents after previously terminating coverage while you remained eligible for coverage under the Contract.

Benefits for Late Entrants are reduced as shown in the Group Highlights section at the beginning of this booklet.]

### [Flexible Dual Choice][d68]

The Flexible Dual Choice product consists of this Delta Dental PPO (PPO) fee-for-service plan and Delta Dental's prepaid dental plan (DeltaCare® USA). The Primary Enrollee and his/her covered dependents may move from this PPO plan to the DeltaCare USA plan or from the DeltaCare USA plan to this PPO plan on a monthly basis. The Primary Enrollee and his/her covered dependents will only be covered under one plan at a time. To make this change, the Primary Enrollee must notify Flexible Dual Choice's Customer Service department at (866) 225-1112 by the 15<sup>th</sup> of the month. The dental plan change will be effective the first day of the following month. The Benefits, Limitations and Exclusions listed in this booklet apply when the Enrollee is covered under the PPO plan.]

Treatment in progress must be completed under the plan in which treatment is started. No plan changes may be made while the Primary Enrollee and his/her covered dependents are undergoing dental treatment.

### [Loss of Eligibility]

Your coverage ends on the [last day of the month][D69][day][D70] you [stop working for the Contractholder /are no longer an Eligible Member of the Contractholder, stop paying the required premiums for coverage][D71] or immediately when this program ends. Your dependents lose coverage when your coverage ends or on the date when dependent status is lost.

### Continuation of Benefits

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within [31] days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

### [Strike, Lay-off and Leave of Absence][D72]

You and your dependents will not be covered for any dental services received while you are on strike, lay-off, leave of absence, other than [an approved leave of absence or][D73] as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law\*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same [Contract/Calendar][D74] Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different [Contract/Calendar][D75] Year, new Deductibles and maximums will apply.

Coverage will resume [the first day of the month after][D76][the date][D77] you return to work, provided you submit an enrollment card requesting that coverage be reactivated.

\*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

**Important:** The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same [Contract/Calendar] [D78] Year, Deductibles and maximums will resume as if you were never gone.]

### **[Continued Coverage under USERRA]**[D79]

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.]

### **[Continuation of Coverage Under COBRA]**[D80]

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).]

## **BENEFITS, LIMITATIONS AND EXCLUSIONS**[D81]

We will pay the Benefits for the types of dental services as described below. We will pay Benefits only for covered services. The services provided through the Contract are described in the Group Highlights section at the beginning of this booklet. The Contract covers several categories of benefits when a Provider provides the services and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time, therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, for specific services are listed in the Group Highlights section. If you receive dental services from a Provider outside the state of XXXXX, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown [in the Group Highlights section/below][D82], subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

## Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in the Group Highlights section. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

## Maximum Amount

Most dental programs have a Maximum Amount. This is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in the Group Highlights section. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

## Benefits

To help you understand the types of procedures that are included in each category, the following is a description of each of the categories of services that are covered under the Contract.

[We will pay the Contract Benefit Level of Maximum Contract Allowance shown [in the Group Highlights section/below] for the following services:][d83]

### Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Provider in choosing required dental treatment.
- Preventive: cleaning, topical application of fluoride solutions and space maintainers. Note that periodontal cleaning in the presence of gingival inflammation is considered to be periodontal and is covered as a [Basic Benefit][D84].
- [[D85]Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]

### Basic Benefits:

- [[D86]Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).]
- General Anesthesia or IV Sedation: when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
- [[D87]Endodontics: treatment of diseases and injuries of the tooth pulp.]
- [[D88]Periodontics: treatment of gums and bones supporting teeth.]
- Palliative: emergency treatment to relieve pain.



- **[[D89]]** Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.]
- **[[D90]]** Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
- **[[D91]]** Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.]

### Major Benefits:

- **[[D92]]** Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).]
- **[[D93]]** Endodontics: treatment of diseases and injuries of the tooth pulp.]
- **[[D94]]** Periodontics: treatment of gums and bones supporting teeth.]
- **[[D95]]** Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.]
- **[[D96]]** Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.]

### [Orthodontic Benefits:]**[[D97]]**

Procedures performed by a Provider, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.]

### [Temporomandibular Joint Dysfunction (TMJ) Benefits:]**[[D98]]**

Intra-oral services provided by a licensed Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofascial pain dysfunction or malfunction of the temporomandibular (jaw) joint.]

### [Implant Benefits:]**[[D99]]**

Procedures performed by a Provider for: endodontic, endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis.]

### [Dental Accident Benefits:

An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and stayplate.]]**[[D100]]**

**Note on additional benefits during pregnancy** - When an Enrollee is pregnant, we will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each [12 month period, Calendar Year, Contract Year]**[[D101]]** while the Enrollee is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

### Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes Limitations and Exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. Please read the following sections to help you understand the limitations and exclusions of this dental plan.

## Limitations

Benefits to Enrollees are limited as follows:

### **Limitations on Diagnostic and Preventive Benefits:**

- We will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) and topical application of fluoride solutions no more than [twice in any 12 month] [D102] period. [Note that periodontal cleanings are covered as a [Basic Benefit] and routine cleanings are covered as a Diagnostic and Preventive Benefit.] [D103] See note on additional benefits during pregnancy.
- Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- X-ray limitations:
  - (1) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Provider's Accepted Fee for a complete intraoral series.
  - (2) When a panoramic film is submitted with supplemental film(s), we will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - (3) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.
  - (4) A complete intraoral series and panoramic film by the same Provider/Provider office are each limited to once every [five (5) [D104]] years.
  - (5) Bitewing x-rays [D105] are limited to [two (2) times in any 12 month period] when provided to Enrollees under age 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries.
- [[D106] Topical application of fluoride solutions is limited to Enrollees to age 19].
- Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14]. [D107] For Enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridge or removable partial denture can be placed.
- Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when Orthodontic services are a covered Benefit.
- [[D108] Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.]

### **Limitations on Basic Benefits:**

- [[D109] Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.]
- We will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months [D110]] of treatment if the service is provided by the same Provider/Provider office.

- We limit payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, we may allow stainless steel crowns on permanent teeth as a [Major Benefit.][D111]
- [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider/Provider office[d112].]
- [[D113]Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing. See note on additional benefits during pregnancy.]

#### **Limitations on Major Benefits:**

- Crowns and inlays/onlays are covered no more often than once in any [five (5) year period][D114] except when we determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Prosthodontic appliances [and/or implants] [D115] that were provided under any Delta Dental program will be replaced only after [five (5) years][D116] have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. [Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. We will not pay for bone grafts provided with implants on the same day of service. Our payment for implant removal is limited to one (1) for each implant during your lifetime whether provided under a Delta Dental program or any other dental care plan.]
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- [[D117]The initial installation of a prosthodontic appliance [and/or implants][d118] is not a Benefit unless the prosthodontic appliance [and/or implant, bridge][d119] or denture is made necessary by natural, permanent teeth extraction occurring during a time you were eligible [under a Delta Dental program / or Contractholder's prior plan.][D120]
- We limit payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement.
  - (1) Denture rebase is limited to one (1) per arch in a 24 month period.
  - (2) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- [We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture[d121].]

#### **[Limitations on Orthodontic Benefits:][D122]**

- The maximum amount payable for each Enrollee during the [Enrollee's lifetime/Calendar Year/Contract Year] is shown in the Group Highlights section[d123].
- [[D124]Orthodontic Benefits will be provided in two (2) payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months of less, one (1) payment will be made.]



- Benefits are not paid to repair or replace any orthodontic appliance received under this program.
- Benefits are not provided for orthodontic retreatment procedures.
- Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the Orthodontic Contract Benefit Level and maximum if covered as Benefits under our standard processing policies..
- **[[D125]**Orthodontic Benefits are limited to dependent child Enrollees under the age of 19 or [25 if full-time student]].

**[Limitations on TMJ Benefits: [D126]**

- TMJ Benefits are subject to all the Limitations, Exclusions and other terms of this dental care program.
- We will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health program which provides TMJ Benefits.
- Benefits are limited to those intra-oral services which would normally be provided by a licensed Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
- Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this program are excluded.
- Any procedure paid under any other category of Benefits by this program is not covered as a TMJ Benefit.]

**[Limitations on Implant Benefits: [D127]**

- Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in the Contract. Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
- We will not pay to replace any implant that you received in the previous five (5) years.
- We will not pay for bone graphs provided with implants on the same day of service.
- We will pay for implant removal only when the Enrollee's coverage includes Implant Benefits and is limited to one (1) for each implant during your lifetime whether provided under us or any other dental care plan.
- Prosthodontic devices and procedures associated with, but not included within the definition of "Implants" are not subject to the Implant Maximum.]

**[Limitations on Dental Accident Benefits: [D128]**

- The dental accident must occur while you are covered under the Contract.
- Services and procedures must be provided within 180 days following the dental accident and while you are covered under the Contract.]

**Limitations on All Benefits - Optional Services:** Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- **[[D129]**a composite restoration instead of an amalgam restoration on posterior teeth;]
- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
- an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

## **Exclusions**

The Contract covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your Provider.

We do not pay benefits for:

- treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.
- maxillofacial prosthetics.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects, illness, injury or birth abnormalities.
- treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- any Single Procedure started prior to the date you became eligible for services under this plan.
- prescribed drugs, medication, pain killers, antimicrobial agents or experimental procedures.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- fixed bridges and removable partials for Enrollees under age 16.
- interim implants.
- resin-based inlays and onlays.
- overdentures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- services or supplies covered by any other health plan of the Contractholder.
- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

- [[D130]]the initial placement of any prosthodontic appliance [or implants], [D131]unless such placement is needed to replace one or more natural, permanent teeth extracted while you are covered under the Contract or was covered under [any dental care program with us / the Contractholder's prior dental plan[D132]]. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.]
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefit section, if applicable.
- procedures performed for the purpose of orthodontic treatment except as provided under the Orthodontic Benefit section, if applicable.
- services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ) except as provided under the TMJ Benefit section, if applicable.
- [[D133]]services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures except as provided under the Implant Benefit section, if applicable.]
- [[D134]]services not included on the Table of Allowances.]
- [[D135]]services or supplies for oral surgery, general anesthesia or IV sedation, palliative treatment, or sealants.]
- [[D136]]services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [[D137]]services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth.)
- [[D138]]services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations or treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).]
- [[D139]]services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).]
- [[D140]]services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations).]
- [[D141]]services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges)].

## PRE-TREATMENT ESTIMATES

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any deductibles, so please remember to figure in your deductible if necessary.

## COORDINATION OF BENEFITS

[[D142]We coordinate the Benefits under the Contract with your Benefits under any other group or prepaid program or Benefit plan including another Delta Dental. (This does not apply to a blanket school accident policy.) Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Provider's fees for the covered services.]

[[D143]We coordinate the Benefits under the Contract with your Benefits under any other group or prepaid program or insurance policy designed to fully integrate with other policies. Benefits under this program may be reduced so that combined coverage does not exceed the Maximum Contract Allowance.]

If this is the "primary" program, we will not reduce Benefits, but if the other program is the primary one, we will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- How do we determine which Plan is the "primary" program?
  - (1) If the other Plan is not primarily a dental plan, this Plan is primary, except the Enrollee's medical plan, if any, will be primary for oral surgery procedures covered under such plan.
  - (2) If the other Plan is a dental program, the following rules are applied.
    - a) the Plan covering you as an employee is primary over a Plan covering you as a dependent.
    - b) the Plan covering you as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      - i) secondary to the Plan covering the insured person as a dependent and
      - ii) primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
  - (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
    - c) However, if the other Plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
    - d) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).

- (4) The benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (5) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following will be the order of benefit determination:
  - a) First, the benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
  - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (6) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the Plan which covered you for the shorter term.

## SELECTING YOUR PROVIDER

### Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a PPO Provider, Premier or a Non-Delta Dental Provider. In addition, you and your family members can see different Providers.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a PPO Provider.** To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

### Locating a Delta Dental PPO Provider

There are two ways in which you can locate a PPO Provider near you:

- You may access information through our web site at [www.deltadentalins.com](http://www.deltadentalins.com). This web site includes a Provider search function allowing you to locate PPO Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 800-521-2651 and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## HOW CLAIMS ARE PAID

### Payment for Services — PPO Provider

Payment for covered services performed for you by a PPO Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim, [the amount shown on the Table of Allowances] or the PPO Provider's Contracted Fee. PPO Providers have agreed to accept the PPO Provider's Contracted Fee as the full charge for covered services. PPO Providers have contractually agreed to charge no more than the PPO Provider's Contracted Fee even for services that are not covered under the Contract provided the service(s) are included in their agreement with us.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Group Highlights section. Delta Dental's Payment is sent directly to the PPO Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

### **Payment for Services — Premier Provider**

Payment for covered services performed for you by a Premier Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim, [the amount shown on the Table of Allowances] or the PPO Provider's Contracted Fee for a [PPO Provider in the same geographic area/Program Allowance]. Premier Providers have agreed to accept the Premier Provider's Contracted Fee as the full charge for covered services. Premier Providers have contractually agreed to charge no more than Premier Provider's Contracted Fee even for services that are not covered under the Contract provided the service(s) are included in their agreement with us.

### **Payment for Services — Non-Delta Dental Provider**

Payment for services performed for you by a Non-Delta Dental Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Group Highlights section. Non-Delta Dental Providers have no agreement with Delta Dental and are free to balance bill you for any difference between what Delta pays and the Submitted Fee.

When dental services are received from a Non-Delta Dental Provider, Delta Dental's Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Delta Dental Provider's actual charges, your out-of-pocket cost may be significantly higher.

### **How to Submit a Claim**

Delta Dental does not require special claim forms. However, most dental offices do have Claim Forms available. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

*Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809*

### **Payment Guidelines**

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 [d144] months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO or Premier Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO or Premier Provider that you were an Enrollee of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all PPO Providers and Premier Providers how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any services are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact us.

## COMPLAINTS AND APPEALS

Our commitment to you is to ensure quality throughout the entire dental benefit process: from the courtesy extended to you by our Customer Service Representatives to the dental services provided by PPO and Premier Providers. If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our web site at [www.deltadentalins.com](http://www.deltadentalins.com)

Complaints or Appeals regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 800-521-2651.

When you write, please include the name of the Enrollee, the Primary Enrollee's name and ID number, and your telephone number on all correspondence. You should also include a copy of the claim form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any complaint, or appeal process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to us giving reasons why you believe the denial was wrong. You may also ask us to examine any additional information you include that may support your complaint, or appeal.

Send your complaint, or appeal to us at the address shown below:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809

We will send you a written acknowledgment within 5 days upon receipt of your complaint or appeal. We will make a full and fair review within 30 days after we receive the complaint or appeal. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If you believe you need further review of your complaint or appeal you may [file a request with us for a second level review or] contact your state insurance regulatory agency.

## PROVISIONS REQUIRED BY LAW

### Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us, in or near your community or residence. We will in every case hold such information and records confidential.



## Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may download a Claim Form from our web site.

## Written Notice of Claim/Proof of Loss

We must be given written proof of loss within [12 months] [D145] after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within [12 months] [D146] of the termination of the Contract.

## Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

## To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

## Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at enrollment.

## Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.



**Dentegra Company  
TABLE OF ALLOWANCES**

<b>PROCEDURE NUMBER</b>	<b>PROCEDURE DESCRIPTION</b>	<b>TABLE OF ALLOWANCE</b>
<b><u>Clinical Oral Evaluations</u></b>		
D0120	Periodic oral evaluation - established patient.....	26.00
D0140	Limited oral evaluation - problem focused.....	42.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	26.00
D0150	Comprehensive oral evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
D0160	Detailed and extensive oral evaluation - problem focused, by report <i>(limited to one per Provider, all subsequent ones will be benefited as D0120)</i> .....	56.00
D0180	Comprehensive periodontal evaluation - new or established patient <i>(limited to one per Provider, all other evaluations will be benefited as D0120)</i> .....	43.00
<b><u>Radiographs/Diagnostic Imaging</u></b> (Including Interpretation) <i>(Any combination of bitewings, periapicals and panoramic films taken on the same day will be combined as a complete series when the fees are equal to or exceed that of a complete series)</i>		
D0210	Intraoral - complete series (including bitewings) .....	78.00
D0220	Intraoral - periapical - first film .....	16.00
D0230	Intraoral - periapical - each additional film.....	12.00
D0240	Intraoral occlusal film.....	19.00
D0250	Extraoral - first film.....	19.00
D0260	Extraoral - each additional film .....	14.00
D0272	Bitewings - two films .....	25.00
D0273	Bitewings - three films .....	34.00
D0274	Bitewings - four films.....	43.00
D0277	Vertical bitewings - seven to eight films.....	53.00
D0330	Panoramic film .....	70.00
D0340	Cephalometric film <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	70.00
D0350	Oral/facial photographic images <i>(This is a benefit only once per case in conjunction with orthodontic services)</i> .....	42.00
<b><u>Test and Examinations</u></b>		
D0470	Diagnostic casts <i>(This is a benefit only in conjunction with orthodontic services)</i> .....	54.00
<b><u>Dental Prophylaxis</u></b>		
D1110	Prophylaxis - adult .....	54.00
D1120	Prophylaxis - child (to age 14).....	43.00
<b><u>Topical Fluoride - (Office Procedure)</u></b>		
D1203	Topical Application of fluoride - child (through age 13).....	22.00
D1204	Topical Application of fluoride - adult <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
D1206	Topical fluoride varnish; therapeutic Application for moderate to high caries risk patients <i>(subject to age limitation specified by the benefit plan)</i> .....	23.00
<b><u>Other Preventive Services</u></b>		
D1351	Sealant - per tooth .....	28.00
	<i>(benefit to permanent first molars through age 8 and second molars through age 15)</i>	
<b><u>Space Maintainers (Passive Appliances)</u></b>		
D1510	Space maintainers – fixed, unilateral.....	202.00
D1515	Space maintainers – fixed, bilateral.....	310.00
D1520	Space maintainers – removable, unilateral .....	256.00
D1525	Space maintainers – removable, bilateral .....	287.00
D1555	Removal of fixed space maintainer .....	50.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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**Amalgam Restorations (Including Polishing)** (the fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp cap, local anesthesia, polishing, occlusal adjustment, caries, removal and gingivectomy on the same date of service. Replacement of restorations by the same Provider is a benefit after 24 months)

D2140	Amalgam - one surface, primary or permanent.....	59.00
D2150	Amalgam - two surfaces, primary or permanent .....	78.00
D2160	Amalgam - three surfaces, primary or permanent.....	93.00
D2161	Amalgam - four or more surfaces, primary or permanent .....	109.00

**Resin-Based Composite Restorations-Direct**

D2330	Resin-based composite - one surface, anterior.....	71.00
D2331	Resin-based composite - two surface, anterior .....	87.00
D2332	Resin-based composite - three surfaces, anterior.....	109.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) .....	135.00
D2391	Resin-based composite - one surface, posterior .....	59.00
D2392	Resin-based composite - two surfaces, posterior .....	78.00
D2393	Resin-based composite - three surfaces, posterior .....	93.00
D2394	Resin-based composite - four or more surfaces, posterior .....	171.00

Fees for Cast Restorations should include tooth preparation, pulp capping, laboratory costs, temporary restorations, porcelain margins, cement bases, routine buildup/substructure, impressions, local anesthesia, occlusal correction, preparation of the gingival tissue and any recementation or repair within six months.

**Inlay/Onlay Restorations**

D2510	Inlay - metallic - one surface.....	233.00
D2520	Inlay - metallic - two surfaces .....	271.00
D2530	Inlay - metallic - three or more surfaces .....	305.00
D2542	Onlay - metallic - two surfaces .....	353.00
D2543	Onlay - metallic - three surfaces.....	377.00
D2544	Onlay - metallic - four or more surfaces .....	394.00
D2610	Inlay - porcelain/ceramic - one surface.....	233.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	271.00
D2630	Inlay - porcelain/ceramic - three or more surfaces .....	305.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	353.00
D2643	Onlay - porcelain/ceramic - three surfaces.....	377.00
D2644	Onlay - porcelain/ceramic - four or more surfaces .....	394.00

**Crowns-Single Restorations Only**

D2740	Crown - porcelain/ceramic substrate .....	375.00
D2750	Crown - porcelain fused to high noble metal .....	383.00
D2751	Crown - porcelain fused to predominantly base metal .....	341.00
D2752	Crown - porcelain fused to noble metal.....	357.00
D2780	Crown - cast 3/4 high noble metal .....	395.00
D2781	Crown - cast 3/4 predominantly base metal .....	372.00
D2782	Crown - cast 3/4 noble metal.....	386.00
D2783	Crown - cast 3/4 porcelain/ceramic .....	405.00
D2790	Crown - full cast high noble metal .....	372.00
D2791	Crown - full cast predominantly base metal .....	330.00
D2792	Crown - full cast noble metal .....	349.00
D2794	Crown - titanium.....	372.00

**Other Restorative Services**

D2910	Recement inlay, onlay, or partial coverage restoration .....	28.00
D2915	Recement cast or prefabricated post and core .....	28.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D2920	Recement crown.....	28.00
D2930	Prefabricated stainless steel crown - primary tooth.....	136.00
D2931	Prefabricated stainless steel crown - permanent tooth .....	98.00
D2932	Prefabricated resin crown.....	98.00
D2933	Prefabricated stainless steel crown with resin window.....	B/R*
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth .....	B/R*
D2940	Sedative Filling .....	50.00
D2950	Core build-up, including any pins ( <i>considered part of crown fee except in exceptional circumstances or for endodontically treated teeth</i> ).....	78.00
D2951	Pin retention - per tooth, in addition to restoration .....	28.00
D2952	Post and core in addition to crown, indirectly fabricated .....	116.00
D2954	Prefabricated post and core in addition to crown .....	98.00
D2960	Labial veneer (resin laminate) - chairside .....	147.00
D2961	Labial veneer (resin laminate) - laboratory .....	233.00
D2962	Labial veneer (porcelain laminate) - laboratory .....	299.00
D2971	Additional procedures to construct new crown under existing partial denture framework .....	B/R*
D2980	Crown repair .....	B/R*
<b><u>Pulpotomy</u></b>		
D3220	Therapeutic pulpotomy (excluding final restoration).....	81.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.....	81.00
<b><u>Endodontic Therapy</u></b> (Including treatment plan, clinical procedures and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration).....	350.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration).....	415.00
D3330	Endodontic therapy, molar (excluding final restoration).....	527.00
<b><u>Endodontic Retreatment</u></b>		
<i>Retreatment of root canal therapy within 24 months of the initial procedure is included in the original contracted fee when performed by the same Provider or in the original submitted fee when performed by an out-of-network Provider.</i>		
D3346	Retreatment of previous root canal therapy - anterior.....	419.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	496.00
D3348	Retreatment of previous root canal therapy - molar.....	605.00
<b><u>Apexification/Recalcification Procedures</u></b>		
D3351	Apexification/recalcification - initial visit.....	225.00
D3352	Apexification/recalcification - interim medication replacement.....	98.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy).....	332.00
<b><u>Apicoectomy/Periradicular Services</u></b>		
D3410	Apicoectomy/periradicular surgery - anterior .....	273.00
D3421	Apicoectomy/periradicular surgery - bicuspid - (first root).....	341.00
D3425	Apicoectomy/periradicular surgery - molar - (first root).....	400.00
D3426	Apicoectomy/periradicular surgery - (each additional root).....	124.00
D3430	Retrograde filling - per root.....	81.00
D3450	Root amputation - per root.....	186.00
<b><u>Other Endodontic Procedures</u></b>		
D3920	Hemisection (including any root removal), not including root canal therapy .....	186.00
<b><u>Surgical Services (Including usual postoperative care)</u></b>		
<i>On periodontal surgical procedures, the surgery is considered to include any surgical re-entry or scaling and root planing for three years.</i>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant...	245.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	87.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .....	310.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	186.00
D4249	Clinical crown lengthening - hard tissue .....	B/R*
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .....	451.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant .....	270.00
D4270	Pedicle soft tissue graft procedure (limited to two sites per quadrant).....	341.00
D4271	Free soft tissue graft procedure (including donor site surgery) (limited to two sites per quadrant) .....	391.00
<b>Non-Surgical Periodontal Service</b>		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	124.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant .....	74.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis .....	54.00
<b>Other Periodontal Services</b>		
D4910	Periodontal maintenance procedure.....	68.00
<b>Complete Dentures</b> (Includes routine post delivery care and relining for the first six months after placement)		
D5110	Complete denture - maxillary.....	426.00
D5120	Complete denture - mandibular .....	426.00
D5130	Immediate denture - maxillary .....	465.00
D5140	Immediate denture - mandibular.....	465.00
<b>Partial Dentures</b> (Includes routine post delivery care for the first six months after placement)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) .....	295.00
D5212	Mandibular partial denture -resin base (including any conventional clasps, rests and teeth).....	295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	504.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	378.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	378.00
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) .....	310.00
<b>Adjustment to Dentures</b>		
D5410	Adjust complete denture - maxillary .....	37.00
D5411	Adjust complete denture - mandibular.....	37.00
D5421	Adjust partial denture - maxillary .....	37.00
D5422	Adjust partial denture - mandibular.....	37.00
<b>Repairs to Complete Dentures</b>		
D5510	Repair broken complete denture base .....	81.00
D5520	Replace missing broken tooth - complete denture (each tooth).....	74.00
<b>Repairs to Partial Dentures</b>		
D5610	Repair resin denture base .....	81.00
D5620	Repair cast framework.....	115.00
D5630	Repair or replace broken clasp.....	109.00
D5640	Replace broken teeth - per tooth .....	74.00
D5650	Add tooth to existing partial denture .....	96.00
D5660	Add clasp to existing partial denture.....	109.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Denture Rebase Procedures</u></b> (Any rebase includes relining and any adjustments for six months following placement. One rebase per arch is covered in a 24 month period)		
D5710	Rebase complete maxillary denture .....	248.00
D5711	Rebase complete mandibular denture.....	248.00
D5720	Rebase maxillary partial denture .....	223.00
D5721	Rebase mandibular partial denture .....	223.00
<b><u>Denture Reline Procedures</u></b>		
D5730	Reline complete maxillary denture (chairside) .....	144.00
D5731	Reline complete mandibular denture (chairside).....	144.00
D5740	Reline maxillary partial denture (chairside) .....	136.00
D5741	Reline mandibular partial denture (chairside).....	136.00
D5750	Reline complete maxillary denture (laboratory) .....	217.00
D5751	Reline complete mandibular denture (laboratory) .....	217.00
D5760	Reline maxillary partial denture (laboratory).....	205.00
D5761	Reline mandibular partial denture (laboratory).....	205.00
<b><u>Interim Prosthesis</u></b>		
D5820	Interim partial denture - maxillary .....	175.00
D5821	Interim partial denture - mandibular.....	175.00
<b><u>Other Removable Prosthetic Services</u></b>		
D5850	Tissue conditioning - maxillary .....	47.00
D5851	Tissue conditioning - mandibular .....	47.00
<b><u>Maxillofacial Prosthetics</u></b>		
D5900-5999 Maxillofacial prosthetic procedures are generally not benefits of Delta Dental programs. When covered, they follow the benefits required under state regulatory guidelines, and typically are limited to services provided to newborn, dependent children for medically diagnosed congenital defects, birth abnormalities.		
<b><u>Implant Services</u></b>		
<b><u>Pre-Surgical Services</u></b>		
D6190	Radiographic/surgical implant index.....	B/R*
<b><u>Surgical Services</u></b>		
D6010	Surgical placement of implant body: endosteal implant .....	0.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant..... (Delta Dental considers this procedure part of the transitional prosthesis which is not a covered benefit)	0.00
D6040	Surgical placement: eposteal implant.....	0.00
D6050	Surgical placement: transosteal implant.....	0.00
<b><u>Implant Supported Prosthetics</u></b>		
<b><u>Supporting Structures</u></b>		
D6055	Dental implant supported connecting bar .....	0.00
D5212	Mandibular abutment — includes placement .....	0.00
D6056	Prefabricated abutment – includes placement .....	0.00
D6057	Custom abutment — includes placement.....	0.00
<b><u>Implant/Abutment Supported Removable Dentures</u></b>		
D6053	Implant/abutment supported removable denture for completely edentulous arch .....	0.00
D6054	Implant/abutment supported removable denture for partially edentulous arch .....	0.00
<b><u>Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)</u></b>		
D6078	Implant/abutment supported fixed denture for completely edentulous arch.....	0.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch .....	0.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
<b><u>Single Crowns, Abutment Supported</u></b>		
D6058	Abutment supported porcelain/ceramic crown .....	0.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	0.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	0.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	0.00
D6062	Abutment supported cast metal crown (high noble metal) .....	0.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	0.00
D6064	Abutment supported cast metal crown (noble metal) .....	0.00
D6094	Abutment supported crown — (titanium) .....	0.00
<b><u>Single Crowns, Implant Supported</u></b>		
D6065	Implant supported porcelain/ceramic crown .....	0.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) .....	0.00
D6067	Implant supported metal crown (titanium, titanium alloy, noble metal) .....	0.00
<b><u>Fixed Partial Denture, Abutment Supported</u></b>		
D6068	Abutment supported retainer for porcelain/ceramic FPD .....	0.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	0.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) .....	0.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	0.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal) .....	0.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal) .....	0.00
D6074	Abutment supported retainer for cast metal FPD (noble metal) .....	0.00
D6194	Abutment supported retainer crown for FPD — (titanium) .....	0.00
<b><u>Fixed Partial Denture, Implant Supported</u></b>		
D6075	Implant supported retainer for ceramic FPD .....	0.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) .....	0.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) .....	0.00
<b><u>Other Implant Services</u></b>		
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis .....	0.00
D6090	Repair implant supported prosthesis .....	B/R*
D6095	Repair implant abutment .....	B/R*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment .....	0.00
	<i>(D6091 is a benefit only after the prosthodontic time limitation (usually 5 years) has elapsed since the implant attachment was placed)</i>	
D6092	Recement implant/abutment supported crown .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6093	Recement implant/abutment supported fixed partial denture .....	0.00
	<i>(Any recementation within six months after placement of the appliance is considered to be included in the initial placement. Benefits may be paid for one recementation after six months)</i>	
D6094	CDT coding places procedure D6094 immediately following D6064 .....	0.00
D6190	CDT coding places procedure D6190 immediately before D6010 .....	0.00
D6194	CDT coding places procedure D6194 immediately following D6074 .....	0.00
D6199	Unspecified implant procedure .....	B/R*
<b><u>Fixed Partial Denture Pontics</u></b>		
D6205	Pontic - indirect resin based composite .....	332.00
D6210	Pontic - cast high noble metal .....	370.00
D6211	Pontic - cast predominantly base metal .....	332.00
D6212	Pontic - cast noble metal .....	357.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D6214	Pontic - titanium .....	370.00
D6240	Pontic - porcelain fused to high noble metal .....	369.00
D6241	Pontic - porcelain fused to predominantly base metal.....	346.00
D6242	Pontic - porcelain fused to noble metal .....	353.00
<b><u>Fixed Partial Denture Retainers—Inlays/Onlays</u></b>		
D6545	Retainer - cast metal for resin bonded fixed prosthesis .....	155.00
D6600	Inlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6602 will be given</i> ) .....	260.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6603 will be given</i> ) .....	302.00
D6602	Inlay - cast high noble metal, two surfaces .....	260.00
D6603	Inlay - cast high noble metal, three or more surfaces .....	302.00
D6604	Inlay - cast predominately base metal, two surfaces.....	260.00
D6605	Inlay - cast predominately base metal, three or more surfaces .....	302.00
D6606	Inlay - cast noble metal, two surfaces .....	260.00
D6607	Inlay - cast noble metal, three or more surfaces .....	302.00
D6608	Onlay - porcelain/ceramic, two surfaces ( <i>an alternate benefit of D6610 will be given</i> ).....	361.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ( <i>an alternate benefit of D6611 will be given</i> ).....	388.00
D6610	Onlay - cast high noble metal, two surfaces.....	361.00
D6611	Onlay - cast high noble metal, three or more surfaces.....	388.00
D6612	Onlay - cast predominately base metal, two surfaces.....	361.00
D6613	Onlay - cast predominately base metal, three or more surfaces .....	388.00
D6614	Onlay - cast noble metal, two surfaces.....	361.00
D6615	Onlay - porcelain/ceramic, three or more surfaces .....	388.00
D6624	Inlay - titanium .....	302.00
D6634	Onlay - titanium.....	388.00
<b><u>Fixed Partial Denture Retainers—Crowns</u></b>		
D6710	Crown - indirect resin based composite .....	B/R*
D6750	Crown - porcelain fused to high noble metal .....	383.00
D6751	Crown - porcelain fused to predominantly base metal .....	341.00
D6752	Crown - porcelain fused to noble metal.....	357.00
D6780	Crown - 3/4 cast high noble metal .....	395.00
D6781	Crown - 3/4 cast predominantly base metal .....	372.00
D6782	Crown - 3/4 cast noble metal .....	386.00
D6783	Crown - 3/4 cast porcelain/ceramic ( <i>an alternate benefit of D6780 will be given</i> ) .....	405.00
D6790	Crown - full cast high noble metal .....	372.00
D6791	Crown - full cast predominantly base metal .....	330.00
D6792	Crown - full cast noble metal .....	349.00
D6794	Crown - titanium .....	378.00
<b><u>Other Fixed Partial Denture Services</u></b>		
D6930	Recement fixed partial denture.....	39.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.....	124.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.....	98.00
D6973	Core buildup for retainer, including any pins .....	96.00
D6980	Fixed partial denture repair.....	B/R*
<b><u>Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7140	Extraction, erupted tooth or exposed root (elevation &/or forceps removal) .....	62.00
<b><u>Surgical Extractions</u></b> (Includes local anesthesia, suturing, if needed and routine postoperative care)		
D7210	Surgical removal of erupted tooth.....	118.00
D7220	Removal of impacted tooth - soft tissue .....	155.00
D7230	Removal of impacted tooth - partially bony .....	205.00
D7240	Removal of impacted tooth - completely bony .....	242.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D7250	Surgical removal of residual tooth roots (cutting procedure).....	118.00
<b>Other Surgical Procedures</b>		
D7280	Surgical access of an unerupted tooth .....	155.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	B/R*
D7285	Biopsy of oral tissue - hard (bone, teeth) .....	158.00
D7286	Biopsy of oral tissue - soft .....	118.00
D7290	Surgical repositioning of teeth .....	B/R*
<b>Alveoloplasty – Surgical Preparation of Ridge</b>		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	121.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	73.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ( <i>usually in preparation for prosthesis</i> ).....	167.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	101.00
<b>Vestibuloplasty</b>		
D7340	Vestibuloplasty - ridge extension - (secondary epithelialization).....	161.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachments and management of hypertrophied and hyper plastic tissue) .....	326.00
<b>Surgical Excision of Soft Tissue Lesions</b>		
D7410	Excision of benign lesion to 1.25 cm .....	B/R*
D7411	Excision of benign lesion diameter greater than 1.25 cm .....	B/R*
D7412	Excision of benign lesion complicated.....	B/R*
D7413	Excision of malignant lesion, up to 1.25 cm .....	B/R*
D7414	Excision of malignant lesion greater than 1.25 .....	B/R*
D7415	Excision of malignant lesion, complicated.....	B/R*
<b>Surgical Excision of Intra-Osseous Lesions</b>		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.....	B/R*
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7450	Removal of benign odontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7451	Removal of benign odontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7460	Removal of benign nonodontogenic cyst/tumor - lesion diameter up to 1.25 cm .....	B/R*
D7461	Removal of benign nonodontogenic cyst/tumor - lesion diameter greater than 1.25 cm .....	B/R*
D7465	Destruction of lesion(s) by physical or chemical methods.....	B/R*
<b>Excision of Bone Tissue</b>		
D7471	Removal of lateral exostosis (maxilla or mandible) .....	524.00
D7472	Removal of torus palatinus .....	524.00
D7473	Removal of torus mandibularis.....	524.00
<b>Surgical Incision</b>		
D7510	Incision and drainage of abscess - intraoral soft tissue.....	B/R*
D7520	Incision and drainage of abscess - extraoral soft tissue.....	B/R*
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue .....	B/R*
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system.....	B/R*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.....	B/R*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.....	B/R*
<b>Treatment of Fractures-Simple</b>		
D7610	Maxilla - open reduction (teeth immobilized, if present) .....	B/R*
D7620	Maxilla - closed reduction (teeth immobilized, if present).....	B/R*
D7630	Mandible - open reduction (teeth immobilized, if present).....	B/R*



PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
D7640	Mandible - closed reduction (teeth immobilized, if present) .....	B/R*
D7650	Malar and/or zygomatic arch - open reduction .....	B/R*
D7660	Malar and/or zygomatic arch - closed reduction.....	B/R*
D7670	Alveolus - closed reduction, may include stabilization of teeth .....	B/R*
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches .....	B/R*
<b><u>Repair of Traumatic Wounds</u></b>		
D7910	Suture - up to 5cm ( <i>when performed in conjunction with extractions, this service is considered to be included as part of the extraction</i> ) .....	B/R*
<b><u>Complicated Suturing</u></b> (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)		
D7911	Complicated suture - up to 5 cm.....	B/R*
D7912	Complicated suture - greater than 5 cm .....	B/R*
<b><u>Other Repair Procedures</u></b>		
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	B/R*
D7970	Excision of hyperplastic tissue - per arch .....	B/R*
D7971	Excision of pericoronal gingiva.....	B/R*
<b><u>Orthodontics</u></b>		
<i>(Delta Dental's allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). Delta Dental will make an allowance for the cost of a standard orthodontic treatment when specialized orthodontic appliances or procedures are chosen for aesthetic considerations)</i>		
<b><u>Delta Dental Limited Orthodontic Treatment</u></b>		
D8010	Limited orthodontic treatment of the primary dentition .....	0.00
D8020	Limited orthodontic treatment of the transitional dentition.....	0.00
D8030	Limited orthodontic treatment of the adolescent dentition.....	0.00
D8040	Limited orthodontic treatment of the adult dentition .....	0.00
<b><u>Interceptive Orthodontic Treatment</u></b>		
D8050	Interceptive orthodontic treatment of the primary dentition .....	0.00
D8060	Interceptive orthodontic treatment of the transitional dentition.....	0.00
<b><u>Comprehensive Orthodontic Treatment</u></b>		
D8070	Comprehensive orthodontic treatment of the transitional dentition .....	0.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition .....	0.00
D8090	Comprehensive orthodontic treatment of the adult dentition.....	0.00
<b><u>Minor Treatment to Control Harmful Habits</u></b>		
D8210	Removable appliance therapy .....	0.00
	<i>(This procedure is an orthodontic service only, and is not equivalent to a night guard, occlusal orthotic device, bite guard or occlusal splint which are provided for non-orthodontic purposes)</i>	
D8220	Fixed appliance therapy .....	0.00
<b><u>Other Orthodontic Services</u></b>		
D8660	Pre-orthodontic treatment visit.....	0.00
	<i>(Equivalent to procedure D0150)</i>	
D8670	Periodic orthodontic treatment visit (as part of contract).....	0.00
	<i>(Delta Dental considers periodic treatment visits to be part of, and included in the contracted fees for, limited, interceptive and comprehensive orthodontic treatment)</i>	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s]) .....	0.00
D8690	Orthodontic treatment (alternative billing to a contract fee) .....	0.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers.....	0.00
D8999	Unspecified orthodontic procedure.....	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TABLE OF ALLOWANCE
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#### **Adjunctive General Services**

D9110 Palliative (emergency) treatment of dental pain - minor procedures..... 50.00

#### **Anesthesia**

D9220 Deep sedation/general anesthesia - first 30 minutes ..... 143.00

D9221 Deep sedation/general anesthesia - each additional 15 minutes..... 31.00

D9241 Intravenous conscious sedation/analgesia - first 30 minutes ..... 157.00

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes ..... 29.00

**Professional Consultation** *(Delta Dental considers this procedure to be for a consultation by a specialist whose opinion or advice has been requested regarding a specific problem when routine diagnostic procedures have been performed by a general dentist and the treatment is not provided by the specialist).*

D9310 Consultation - diagnostic service provided by Provider or physician other than requesting Provider  
or physician..... 54.00

#### **Miscellaneous Services**

D9930 Treatment of complications (post-surgical) - unusual circumstances ..... B/R\*

\*By Report – Delta Dental will determine the maximum allowance based on a narrative report submitted by the Provider.

**NOTE: The procedures described and allowances indicated on this table are subject to the terms of the Contract and Delta Dental processing policies and may be limited or excluded.**

Note: The above codes and nomenclature are copyright of the American Dental Association. Notes in italic type have been added by Delta Dental for clarification of its processing policies with respect to these procedures and are not part of the ADA's nomenclature.

**[D147]**

## **NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Delta Dental protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program, and we will notify you of how you can receive a copy of this notice every three years.

### **Permitted Uses and Disclosures of Your PHI**

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Delta Dental in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Delta Dental in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

## **Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

*For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*

- Uses and/or disclosures of PHI for payment.

*For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*

- Uses and/or disclosures of PHI for health care operations.

*For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

## **Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

## **Disclosures Delta Dental Makes With Your Authorization**

Delta Dental will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

## **Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Delta Dental office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your

request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by e-mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

### **Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Delta Dental has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

### **Contact**

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023

Phone: 770-641-5100

**This notice is effective on and after July 1, 2006.**

## Main document changes and comments

Page 1: Comment [D1]	Dentegra	6/18/2009 2:55:00 PM
Enter Contractholder name as it appears on the application.		
Page 1: Comment [D2]	Dentegra	6/18/2009 2:55:00 PM
Enter Contractholder's group number as it appears on the application.		
Page 1: Comment [D3]	Dentegra	6/18/2009 2:55:00 PM
Enter original effective date as it appears on the application.		
Page 1: Comment [D4]	Dentegra	6/18/2009 2:55:00 PM
Use revised date when notification of change is received, which requires a modification/revision to the Evidence of Coverage.		
Page 2: Comment [D5]	Dentegra	6/18/2009 2:55:00 PM
Choose Calendar or Contract Year sentence based on application.		
Page 2: Comment [D6]	Dentegra	6/18/2009 2:55:00 PM
Time period would be changed to match what the group requested on application.		
Page 2: Comment [D7]	Dentegra	7/17/2009 8:19:00 AM
Use this option if program is PPO/PPO or PPO/Program Allowance; this is standard. Delete if another option is purchased. Benefits vary by group coinsurance percentages. Options are 0-100%. In and out-of network benefits may vary, but not any more than twenty-five percent (25%). May also be sold as a high-low plan where Enrollee would choose which coverage they wanted; however, Enrollees would only be covered under one option for any given year. Basic, major, Ortho, TMJ and Implants would be deleted if not purchased.		
Page 2: Comment [D8]	Dentegra	6/18/2009 2:55:00 PM
Use this option if PPO with Table of Allowances is purchased; otherwise, delete. The coinsurance % options are 0% to 100%. In-Network and Out-of-Network % are the same. May be sold as a high/low program where percentages would be different. Enrollee would only be covered under one option at any given year. Ortho and TMJ may be deleted if not included in plan design chosen by the Contractholder. If sold as a step plan, the following statement would be inserted into the Benefit Section: "Benefits would increase each year either every January 1st or the anniversary of the Primary Enrollee."		
Page 2: Comment [D9]	Dentegra	6/18/2009 2:55:00 PM

Include this section if Contractholder selects a "Late Entrant Provision"; otherwise delete. 12 months is standard but other time frames may be requested by Contractholder.

Page 3: Comment [D10]	Dentegra	6/18/2009 2:55:00 PM
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Include this section if waiting periods apply; otherwise, delete. Time period option for all waiting periods is 6 months to 36 months.

Page 3: Comment [D11]	Dentegra	6/18/2009 2:55:00 PM
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Include paragraph if waiting period applies to Basic, Major, and TMJ. Add or delete Benefits as indicated on approved application. If different waiting periods apply to each benefit, a new bullet point would be used for each benefit indicating the different time period.

Page 3: Comment [D12]	Dentegra	6/18/2009 2:55:00 PM
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This sentence is standard - dependent waiting period is determined by primary Enrollee's length of coverage. Delete this sentence if alternative is approved (dependent waiting period determined by dependent's own length of coverage).

Page 3: Comment [D13]	Dentegra	6/18/2009 2:55:00 PM
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Use this sentence if Contractholder had prior coverage.

Page 3: Comment [D14]	Dentegra	6/18/2009 2:55:00 PM
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Use if ortho benefit is covered for children only.

Page 3: Comment [D15]	Dentegra	6/18/2009 2:55:00 PM
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Use if ortho benefit is covered for adults and children.

Page 3: Comment [D16]	Dentegra	6/18/2009 2:55:00 PM
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This sentence is standard – dependent waiting period is determined by primary enrollee's length of coverage. Delete this sentence if alternative is approved (dependent waiting period determined by dependent's own length of coverage).

Page 3: Comment [D17]	Dentegra	6/18/2009 2:55:00 PM
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Use this sentence if Contractholder had prior coverage.

Page 3: Comment [d18]	dpctx5	6/18/2009 2:55:00 PM
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Standard - deductible the same for both in- and out-of-network; program option available for different in- and out-of-network if allowed by state regulation and selected by the Contractholder. If an Enrollee switches between in- and out-of-network benefits during the Calendar/Contract Year the Deductible may be adjusted accordingly

Page 3: Comment [D19]	Dentegra	6/18/2009 2:55:00 PM
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Use this option for individual deductible. Choose Contract or Calendar Year per application. Range for individual deductible is \$0-\$500. If no deductible applies, the variables would be deleted from the Deductible section. If sold as a high/low plan, there could be a separate deductible for each option.

Page 3: Comment [D20]

Dentegra

6/18/2009 2:55:00 PM

Range for family deductible is \$0-\$1500. Choose Contract or Calendar Year per application. If there is no family deductible, delete.

Page 3: Comment [D21]

Dentegra

6/18/2009 2:55:00 PM

If a lifetime deductible is sold, this option would be used. If a Calendar or Contract Year option is sold, this option would be deleted. Range for a lifetime deductible is \$0 - \$500.

Page 3: Comment [D22]

Dentegra

6/18/2009 2:55:00 PM

Include if Orthodontia has a separate deductible. \$0-\$500 for calendar or contract year and \$0-\$500 for lifetime. Use correct options for items in brackets based on what is shown on the application.

Page 3: Comment [D23]

Dentegra

6/18/2009 2:55:00 PM

Include if TMJ has a separate deductible \$0-\$500 for calendar or contract year and \$0-\$1000 for lifetime.

Page 3: Comment [D24]

Dentegra

6/18/2009 2:55:00 PM

Include if Implant Benefits have a separate Deductible. \$0-\$500 for calendar or Contract Year and \$0-\$1000 for lifetime. Would be indicated in special request section of application.

Page 3: Comment [D25]

Dentegra

6/18/2009 2:55:00 PM

Use this statement if the deductible is waived for D&P. Delete Ortho, Implants or TMJ if those benefits are covered and a deductible applies to each or if those benefits are not covered. However, if those Benefits are covered and a deductible does not apply, keep them in the sentence.

Page 3: Comment [D26]

Dentegra

6/18/2009 2:55:00 PM

This statement would be included if 4th quarter carryover is purchased.

Page 3: Comment [D27]

Dentegra

6/18/2009 2:55:00 PM

Use this statement if there is deductible takeover and it's a Calendar Year with Contractholders effective after Jan 1.



Include this deductible takeover option if there is a separate calendar year deductible for one or more of the Benefits mentioned.

Include this deductible takeover option if there is a separate lifetime deductible for one or more of the Benefits mentioned.

Standard – maximum the same for both in- and out-of-network; program option available for different maximums in- and out-of-network if allowed by state regulations and selected by Contractholder. The combined maximum amount payable each year for In-Network and Out-of-Network Benefits will not exceed the maximum amount for In-Network Benefits. However, if only Out-of-Network Benefits are used for the calendar year, the maximum will not exceed the Out-of-Network maximum.

Annual maximum - Options are \$500 - \$5,000 per period. If sold as a high/low plan, there could be separate maximums for each option. Choose correct option Contract or Calendar Year and per Enrollee or Family per the application. The range can be \$500-\$5,000.

Use this option if there is a lifetime Calendar Year or Contract Year orthodontic maximum. If orthodontia is limited to Children, keep Dependent Child; otherwise, delete. Amounts can be \$500-\$5,000.

Include this option if there is a separate Calendar or Contract Year maximum (choose correct option as indicated on approved application) for TMJ. Separate sentences would be entered if a separate maximum applies for each Benefit. Ranges for separate Calendar Year or Contract Year maximum are \$500-\$5,000

Include this option if there is a separate lifetime maximum for TMJ. Separate sentences would be entered if a separate maximum applies for each Benefit. Ranges for lifetime maximum are \$500-\$5,000.

Based on group application. Options are \$500 - 5,000.

Use if Contractholder purchase the option whereh D&P Benefits do not apply towards the Enrollee's yearly maximum. Standard would be not to include this.

Page 3: Comment [D37]	Dentegra	6/18/2009 2:55:00 PM
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Include if taking over a Calendar Year Contractholder other than on January 1st.

Page 4: Comment [D38]	Dentegra	6/18/2009 2:55:00 PM
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Include if taking over orthodontic, TMJ benefits from prior carrier.

Page 4: Comment [D39]	Dentegra	6/18/2009 2:55:00 PM
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Use this statement if the maximum is waived for D&P.

Page 4: Comment [D40]	Dentegra	6/18/2009 2:55:00 PM
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Choose correct option from the application regarding responsibility for paying premiums.

Page 5: Comment [D41]	Dentegra	6/18/2009 2:55:00 PM
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Include if domestic partners are to be covered; otherwise, delete.

Page 5: Comment [D42]	Dentegra	6/18/2009 2:55:00 PM
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Use "Member" for association contracts; change "Employee" to "Member" throughout EOC where applicable if sold to an association.

Page 5: Comment [D43]	Dentegra	6/18/2009 2:55:00 PM
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Include "retiree" if retirees are to be covered; delete if retirees are not covered.

Page 5: Comment [D44]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder requests limitation for late entrants.

Page 5: Comment [D45]	Dentegra	6/18/2009 2:55:00 PM
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Use this definition when the program is PPO/PPO.

Page 5: Comment [D46]	Dentegra	6/18/2009 2:55:00 PM
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Use this definition when the program is PPO/Program Allowance.

Page 5: Comment [D47]	Dentegra	6/18/2009 2:55:00 PM
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Use this definition when the program has a Table of Allowances.

Page 6: Comment [D48]	Dentegra	6/18/2009 2:55:00 PM
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This definition is used if the program has a Table of Allowances; otherwise, delete.

Page 6: Comment [D49]	Dentegra	6/18/2009 2:55:00 PM
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Include if domestic partners are covered.

Page 6: Comment [d50]	dpcxr5	6/18/2009 2:55:00 PM
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use if dependents are covered until end of the month

Page 6: Comment [D51]	Dentegra	6/18/2009 2:55:00 PM
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Include if domestic partners are covered.

Page 6: Comment [D52]	Dentegra	6/18/2009 2:55:00 PM
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Use this option if Underwriting approves allowing young children to not be covered until the end of the year they turn 4; must be Section 125 and employees pay all of dependent premium. Choose Contract or Calendar Year as indicated on approved application.

Page 7: Comment [d53]	dpcxr5	6/18/2009 2:55:00 PM
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The wording in this section is variable and may be customized for a Contractholder upon request based on information provided in application under plan requirements and/or special requests. Include this option if employer is contributing 100% of premiums for employees; otherwise delete.

Page 7: Comment [D54]	Dentegra	6/18/2009 2:55:00 PM
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Include if employer is paying 100% for dependents; otherwise, delete.

Page 7: Comment [D55]	Dentegra	6/18/2009 2:55:00 PM
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Include if employer contributes 100% for employee only.

Page 7: Comment [D56]	Dentegra	6/18/2009 2:55:00 PM
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Include this sentence and choose appropriate options if Employee and/or Dependents must contribute toward coverage.

Page 7: Comment [D57]	Dentegra	6/18/2009 2:55:00 PM
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Use if Contractholder requests and Underwriting approves that Dependents covered under another group dental plan would not have to be covered under this dental plan too.

Page 7: Comment [D58]	Dentegra	6/18/2009 2:55:00 PM
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Choose this option for Employees if Plan is not a Section 125 plan. (standard)

Page 7: Comment [D59]	Dentegra	6/18/2009 2:55:00 PM
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Use this option is there is a 125 plan. Delete this option if there is not a section 125 plan or if the Contractholder is contributing 100% toward Employees' cost of coverage.

Page 7: Comment [D60]	Dentegra	6/18/2009 2:55:00 PM
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Choose this option for Dependents if Plan is not a Section 125 plan. (standard)

Page 7: Comment [D61]	Dentegra	6/18/2009 2:55:00 PM
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Use this option if there is a 125 plan. Delete this option if there is not a section 125 plan or if the Contractholder is contributing 100% toward Dependents' cost of coverage.

Page 7: Comment [D62]	Dentegra	6/18/2009 2:55:00 PM
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Use this option if Underwriting approves allowing young children to not be covered until the end of the year they turn 4; must be Section 125 and employees pay all of dependent premium. Choose Contract or Calendar Year as indicated on approved application.

Page 7: Comment [D63]	Dentegra	6/18/2009 2:55:00 PM
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Standard where one spouse may be covered as Primary Enrollee and also as a dependent. If both are Primary Enrollees; children may only enroll under one parent.

Page 7: Comment [D64]	Dentegra	6/18/2009 2:55:00 PM
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Option where one spouse may be covered as a Primary Enrollee and also as a dependent of other if both are employees; children may be covered under one or both parents.

Page 7: Comment [D65]	Dentegra	6/18/2009 2:55:00 PM
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Option where one spouse may not be covered as a dependent of other if both are employees; children may be enrolled under only one parent.

Page 7: Comment [D66]	Dentegra	6/18/2009 2:55:00 PM
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Option where one spouse may not be covered as a dependent of other if both are employees; children may be enrolled under one or both parents.

Page 7: Comment [D67]	Dentegra	6/18/2009 2:55:00 PM
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Include section if Contractholder selects this provision. 31 days is standard, but different time frames may be used at the Contractholder's request.

Page 8: Comment [D68]	dpdjr5	6/18/2009 2:55:00 PM
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Use if the Flexible Dual Choice option is selection by the Contractholder; otherwise, delete.

Page 8: Comment [D69]	Dentegra	6/18/2009 2:55:00 PM
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Use if coverage is effective on the first day of the month.

Page 8: Comment [D70]	Dentegra	6/18/2009 2:55:00 PM
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Use if coverage is effective on any day other than the first day of the month.

Page 8: Comment [D71]	Dentegra	6/18/2009 2:55:00 PM
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Standard will be "stop working for Contractholder" for employer groups. Other wording would be used if sold to an association group.

Page 8: Comment [D72]	Dentegra	6/18/2009 2:55:00 PM
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Section would be included for employer/employee group and deleted if sold to an association.

Page 8: Comment [D73]	Dentegra	6/18/2009 2:55:00 PM
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Insert if Contractholder requests or it's noted in the Special Request section of application.

Page 8: Comment [D74]	Dentegra	6/18/2009 2:55:00 PM
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Choose Contract or Calendar Year as indicated on approved application.

Page 8: Comment [D75]	Dentegra	6/18/2009 2:55:00 PM
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Choose Contract or Calendar Year as indicated on approved application.

Page 8: Comment [D76]	Dentegra	6/18/2009 2:55:00 PM
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Use if coverage is effective on the first day of the month.

Page 8: Comment [D77]	Dentegra	6/18/2009 2:55:00 PM
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Use if coverage is effective on the day of hire or any day other than the first day of the month.

Page 9: Comment [D78]	Dentegra	6/18/2009 2:55:00 PM
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Choose Contract or Calendar Year as indicated on approved application.

Page 9: Comment [D79]	Dentegra	6/18/2009 2:55:00 PM
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Section would be included for employer/employee group and deleted if sold to an association.

Page 9: Comment [D80]	Dentegra	6/18/2009 2:55:00 PM
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Section would be included for employer groups only.

Page 9: Comment [D81]	Dentegra	6/18/2009 2:55:00 PM
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The benefits, limitations and exclusions in this section are variable and would be included or deleted based on approved application.

Page 10: Comment [D82]	Dentegra	6/18/2009 2:55:00 PM
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Standard is to include wording regarding the Group Highlight section; however, if an incentive plan is purchased we would use "below" and the information would be added to the Benefits section.

Wording would be added to the bulleted items under Section 4.04 if one of the following Program options is purchased:

**Standard Incentive Plan:**

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>In- Network</i>	<i>Contract Benefit Level</i>		
	<i>Out-of-Network Premier</i>	<i>Non-Delta Dental</i>	
xx%	xx%	xx%	during the Enrollee's first year
xx%	xx%	xx%	during the Enrollee's second year
xx%	xx%	xx%	during the Enrollee's third year
xx%	xx%	xx%	during the Enrollee's fourth year of coverage and thereafter.

Benefits will increase each year if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will either remain at the attained level, drop to the next lowest level or drop to the base level; under no circumstances would it fall below a base benefit level. Percentages could be between 0 and 100%. In and out of network percentages may vary, but not anymore than by twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base level.]

**Partial Benefit Incentive Plan for part-time employees:**

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>In- Network</i>	<i>Contract Benefit Level</i>		
	<i>Out-of-Network Premier</i>	<i>Non-Delta Dental</i>	
xx%	xx%	xx%	during the Enrollee's first year
xx%	xx%	xx%	during the Enrollee's second year
xx%	xx%	xx%	during the Enrollee's third year
xx%	xx%	xx%	during the Enrollee's fourth year of coverage and thereafter.

Benefits will increase each year if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will wither remain at the attained level, drop to the next lowest level or drop to the base level; under no circumstances would it fall below a base benefit level. Percentages could be between 0 and 100% In and out of network percentages may vary, but not any more than twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base

level.]

**Enrollee/Member Incentive Plan:**

Delta Dental shall pay or otherwise discharge the following Contract Benefit Level of the Maximum Contract Allowance for the following services:

<i>Contract Benefit Level</i>		
<i>In-</i>	<i>Out-of-Network</i>	
<i>Network</i>	<i>Premier</i>	<i>Non-Delta Dental</i>

xx%	xx%	xx%	during the Primary Enrollee's first year
xx%	xx%	xx%	during the Primary Enrollee's second year
xx%	xx%	xx%	during the Primary Enrollee's third year
xx%	xx%	xx%	during the Primary Enrollee's fourth year of coverage and thereafter.

Benefits will increase on the anniversary of the Primary Enrollee's Effective Date of Coverage under this Contract. Percentages could be between 0 and 100%. In and out of network benefits may vary, but not any more than twenty-five percent (25%). [Benefits for Enrollees with a break-in-coverage will decrease to the base level.]

Page 10: Comment [D84]

Dentegra

6/18/2009 2:55:00 PM

Standard is for Periodontal to paid as Basic; would be changed if Periodontal is paid other than as Basic.

Page 10: Comment [D85]

Dentegra

6/18/2009 2:55:00 PM

Use if sealants are covered under D&P rather than the standard basic. If covered as standard basic, this item would be deleted.

Page 10: Comment [D86]

Dentegra

6/18/2009 2:55:00 PM

Standard is for Oral Surgery to be paid as Basic, but Contractholder may change or remove.

Page 10: Comment [D87]

Dentegra

6/18/2009 2:55:00 PM

Standard is for Endodontics to be paid as Basic, but Contractholder may change or remove.

Page 10: Comment [D88]

Dentegra

6/18/2009 2:55:00 PM

Standard is for Periodontics to be paid as Basic, but Contractholder may change or remove.

Page 11: Comment [D89]

Dentegra

6/18/2009 2:55:00 PM

Standard is for Sealants to be covered as Basic, but Contractholder may change or remove.

Page 11: Comment [D90]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Restorative to be covered as Basic, but Contractholder may change or remove.

Page 11: Comment [D91]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Denture Repairs to be covered as Basic, but Contractholder may change or remove.

Page 11: Comment [D92]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Oral Surgery to be covered as Basic, but Contractholder may change or remove.

Page 11: Comment [D93]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Endodontics to be paid as Basic, but Contractholder may change or remove.

Page 11: Comment [D94]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Periodontics to be paid as Basic, but Contractholder may change or remove.

Page 11: Comment [D95]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Crowns, Inlays/Onlays and Cast Restorations to be covered as Major, but Contractholder may change or remove.

Page 11: Comment [D96]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for Prosthodontics to be covered as Major, but Contractholder may change or remove. Standard is to include implants in with Prosthodontics. However, Contractholder may choose not to cover implants or to cover implants as a Basic or as a separate Benefits with its own coinsurance percentage. This variable would be deleted or modified as indicated on the approved application. If the Contractholder chooses not to cover implants, it would be added to the Exclusions.

Page 11: Comment [D97]	Dentegra	6/18/2009 2:55:00 PM
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Orthodontics are an optional Benefit that would be included if the Contractholder chose to purchase this coverage for Enrollees.

Page 11: Comment [D98]	Dentegra	6/18/2009 2:55:00 PM
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TMJ is an optional Benefit that would be included if the Contractholder chose to purchase this coverage for enrollees.



Page 11: Comment [D99]	Dentegra	6/18/2009 2:55:00 PM
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This optional benefit would be included if the Contractholder chose to purchase this coverage for its enrollees.

Page 11: Comment [D100]	Dentegra	6/18/2009 2:55:00 PM
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This optional benefit would be included if the Contractholder chose to purchase this coverage for its enrollees.

Page 11: Comment [D101]	Dentegra	6/18/2009 2:55:00 PM
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12 months is standard; may also be Calendar or Contract Year as indicated on the approved application.

Page 12: Comment [D102]	Dentegra	6/18/2009 2:55:00 PM
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Twice in 12 months is standard. May also be calendar year or other time periods requested by Contractholder. Additional cleanings/exams may also be requested.

Page 12: Comment [D103]	Dentegra	6/18/2009 2:55:00 PM
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If periodontal is covered as other than Basic, change this sentence accordingly.

Page 12: Comment [d104]	dp_cxr5	6/18/2009 2:55:00 PM
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Five years is standard; however, 3 years is an option and other time periods may be requested by Contractholder.

Page 12: Comment [D105]	Dentegra	6/18/2009 2:55:00 PM
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Once each 12 months for Enrollees 18 and older and twice each 12 months for Enrollees under 18 is standard; however, Calendar Year or other time periods may be requested by Contractholder. Contractholder may also request different number of x-rays.

Page 12: Comment [D106]	Dentegra	6/18/2009 2:55:00 PM
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Standard is to cover fluoride to age 19; however, Contractholder may request it be limited to certain other age brackets or to cover all (delete limitation if all covered).

Page 12: Comment [D107]	Dentegra	6/18/2009 3:07:00 PM
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14 is Delta Dental's standard but another age may be requested by Contractholder

Page 12: Comment [D108]	Dentegra	6/18/2009 2:55:00 PM
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Use this item if sealants are covered under D&P rather than the standard basic. If

sold as standard basic benefit, this item would be deleted. Age and time limits for sealants may vary based on request by Contractholder. Contractholder may remove.

Page 12: Comment [D109]	Dentegra	6/18/2009 2:55:00 PM
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Standard is for to be covered under Basic. However, a common request from Contractholders is for sealants to be covered as D&P and would be indicated in the special request section of approved application. Choose correct option and delete other reference. Age and time limits for sealants may vary based on request by Contractholder. Contractholder may remove.

Page 12: Comment [D110]	Dentegra	6/18/2009 2:55:00 PM
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Time limit for restorations may be changed based on Contractholder's request.

Page 13: Comment [D111]	Dentegra	6/18/2009 2:55:00 PM
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Standard is to cover as Major; however Contractholder may request as Basic or may be deleted if Contractholder does not want to cover.

Page 13: Comment [d112]	dpdjr5	6/18/2009 2:55:00 PM
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Include if Endodontics covered under Basic. Move to "Limitations on Major Benefits" if Contractholder covered under Major.

Page 13: Comment [D113]	Dentegra	6/18/2009 2:55:00 PM
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Include if Periodontics covered under Basic. Move to "Limitations on Major Benefits" if Contractholder covered under Major. Standard surgery limitation is 3 or 5 years but other time periods may be requested by Contractholder.

Page 13: Comment [D114]	Dentegra	6/18/2009 2:55:00 PM
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Standard options for crown and inlays/onlays time limits are 5 or 9 years; however, it may be changed based on Contractholder's request. Contractholder may remove.

Page 13: Comment [D115]	Dentegra	6/18/2009 2:55:00 PM
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Delete if implants are not covered or covered as separate category. If deleted, reference to implants would be deleted from remainder of section.

Page 13: Comment [D116]	Dentegra	6/18/2009 2:55:00 PM
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Standard options for prosthodontic time limits are 5 or 9 years; however, it may be changed based on Contractholder's request.

Page 13: Comment [D117]	Dentegra	6/18/2009 2:55:00 PM
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Include this limitation if missing teeth are not covered. Delete this exclusion if missing teeth are covered.

Page 13: Comment [d118]	dpcxr5	6/18/2009 2:55:00 PM
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delete if implants are not covered or covered as a separate benefit

Page 13: Comment [d119]	dpcxr5	6/18/2009 3:59:00 PM
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delete if implants are not covered or covered as a separate benefit

Page 13: Comment [D120]	Dentegra	6/18/2009 3:07:00 PM
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Option "under a Delta Dental program" is standard; however, "prior plan" wording is also used if replacing another group dental plan.

Page 13: Comment [d121]	dpdjr5	6/18/2009 2:55:00 PM
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Include if implants are not covered.

Page 13: Comment [D122]	Dentegra	6/18/2009 2:55:00 PM
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Include section if Orthodontic Benefits are purchased.

Page 13: Comment [d123]	dpcxr5	6/18/2009 3:59:00 PM
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Lifetime is standard; however, other options are available if selected by Contractholder including Calendar Year and Contract Year.

Page 13: Comment [D124]	Dentegra	6/30/2009 8:35:00 AM
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Standard is two (2) payments – 50% at initial banding and 50% in 12 months. Other payment frequencies may be requested by the Contractholder.

Page 14: Comment [D125]	Dentegra	6/18/2009 2:55:00 PM
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Use if Ortho Benefit is covered for children only. Include full-time students if indicated on application

Page 14: Comment [D126]	Dentegra	6/18/2009 2:55:00 PM
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Include section if TMJ Benefits are purchased.

Page 14: Comment [D127]	Dentegra	6/18/2009 2:55:00 PM
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Include section if separate Implant Benefits are purchased. 5 years is standard time frame; however, time limit may be changed based on Contractholder's request if approved by Underwriting.

Page 14: Comment [D128]	Dentegra	6/18/2009 2:55:00 PM
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Include section if Accidental Dental Injury Benefits are purchased.

Page 14: Comment [D129]	Dentegra	6/18/2009 2:55:00 PM
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Standard is to include composite wording here; however, some groups may request that the contract cover composite restorations on posterior teeth.

Page 16: Comment [D130]	Dentegra	6/18/2009 2:55:00 PM
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Include this exclusion if missing teeth are not covered. Delete this exclusion if missing teeth are covered.

Page 16: Comment [D131]	Dentegra	6/18/2009 2:55:00 PM
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Include if implants are covered.

Page 16: Comment [D132]	Dentegra	6/18/2009 2:55:00 PM
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Include prior plan wording if we are replacing another group dental plan. Use "any Dental care program with us" wording if not replacing, which is standard.

Page 16: Comment [D133]	Dentegra	6/18/2009 2:55:00 PM
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Include if implants are not covered or they are covered as a separate benefits category.

Page 16: Comment [D134]	Dentegra	6/18/2009 2:55:00 PM
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Include if PPO with Table of Allowances is sold; otherwise, delete this bullet item.

Page 16: Comment [D135]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover Oral Surgery, General Anesthesia, IV Sedation, Palliative Treatment or sealants; otherwise, delete. Changes would be made if Contractholder does not want to exclude all services.

Page 16: Comment [D136]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover endodontics; otherwise, delete.

Page 16: Comment [D137]	Dentegra	6/18/2009 3:59:00 PM
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Would be included if Contractholder did not want to cover periodontics; otherwise, delete.

Page 16: Comment [D138]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover restorative treatment; otherwise, delete.

Page 16: Comment [D139]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover denture repairs; otherwise, delete.

Page 16: Comment [D140]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover crowns, cast restorations and inlays/onlays otherwise, delete.

Page 16: Comment [D141]	Dentegra	6/18/2009 2:55:00 PM
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Would be included if Contractholder did not want to cover prosthodontics; otherwise, delete.

Page 17: Comment [D142]	Dentegra	6/18/2009 2:55:00 PM
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Standard COB option.

Page 17: Comment [D143]	Dentegra	6/18/2009 2:55:00 PM
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Non-Duplication option is non-standard and would be used at request of Contractholder.

Page 19: Comment [d144]	dpcxr5	6/18/2009 2:55:00 PM
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Standard is 12 months however other options available are 6 - 24 months

Page 21: Comment [D145]	Dentegra	7/10/2009 1:51:00 PM
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12 months is standard; however, group may request and Underwriting may approve a reduced time frame down to 90 days.

Page 21: Comment [D146]	Dentegra	7/10/2009 1:52:00 PM
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12 months after Contract Term is standard unless UW approves different run-out period; however, a group could ask for and Underwriting approve a shorter run-out time down to 90 days.

Page 21: Comment [D147]	Dentegra	6/18/2009 3:59:00 PM
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This is a sample table. Procedures covered and maximum allowances will vary depending on the plan purchased by the Contractholder.

Header and footer changes
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Text box changes
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Header and footer text box changes
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Footnote changes
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Endnote changes
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